

JD-ABT-151
XD

A.I.D. EVALUATION SUMMARY - PART I 15N 80512

1. BEFORE FILLING OUT THIS FORM, READ THE ATTACHED INSTRUCTIONS.
2. USE LETTER QUALITY TYPE, NOT "DOT MATRIX" TYPE.

IDENTIFICATION DATA					
A. Reporting A.I.D. Unit: Mission or AID/W Office (ES# _____) <u>USAID/GHANA</u>		B. Was Evaluation Scheduled in Current FY Annual Evaluation Plan? Yes <input checked="" type="checkbox"/> Skipped <input type="checkbox"/> Ad Hoc <input type="checkbox"/> Evaluation Plan Submission Date: FY <u>Q</u>		C. Evaluation Timing Interim <input type="checkbox"/> Final <input checked="" type="checkbox"/> Ex Post <input type="checkbox"/> Other <input type="checkbox"/>	
D. Activity or Activities Evaluated (List the following information for project(s) or program(s) evaluated; if not applicable, list title and date of the evaluation report.)					
Project No.	Project /Program Title	First PROAG or Equivalent (FY)	Most Recent PACD (Mo/Yr)	Planned LOP Cost (000)	Amount Obligated to Date (000)
936-3024	GHANA NATIONAL TRADITIONAL BIRTH ATTENDANTS PROGRAM	1989	1989	\$1,664	\$1,664

ACTIONS		
E. Action Decisions Approved By Mission or AID/W Office Director		
Action(s) Required	Name of Officer Responsible for Action	Date Action to be Completed
Funding and technical assistance will be provided to the NTBA for training an additional 3,000 TBAs and for upgrading the skills of previously trained TBAs.	ACNM	1993-1996
A training consultant will be hired to develop a competency-based teaching/learning model to be used in the development and establishment of a core capability for training and supervision.	ACNM	Nov. 1992
A management systems specialist will be hired to develop a strategy for improving NTBA's ability to plan, monitor and evaluate national TBA activities.	ACNM	Jan. 1993
Support will be provided to the NTBA for revising and developing additional NTBA/MOH materials for the training and support of trainers and TBAs.	ACNM	Nov. 1992

APPROVALS

F. Date Of Mission Or AID/W Office Review Of Evaluation: _____ (Month) _____ (Day) _____ (Year)

G. Approvals of Evaluation Summary And Action Decisions:

Name (Typed)	Project/Program Officer	Representative of Borrower/Grantee	Evaluation Officer	Mission or AID/W Office Director
	D. BLUMBIAGEN		R. WUERTZ	J. B. GOODWIN
Signature				
Date				

ABSTRACT

H. Evaluation Abstract (Do not exceed the space provided)

Summary - The Ghana National Traditional Birth Attendant (NTBA) Program grant was awarded between AID's REDSO/West and Central Africa and the America College of Nurse Midwives. The purpose of the grant was to provide support in the establishment of an NTBA office in Ghana responsible for coordinating, sustaining, monitoring and evaluating an NTBA program in five Ministry of Health (MOH) regions. The NTBA was funded to assist the MOH to expand its primary health care services to rural areas and to identify, train and support traditional birth attendants and their trainers.

In keeping with program objectives, an NTBA office was established. Training was provided to more than 3,000 TBAs, 307 trainers, and 63 master trainers. The project was found to have had a significant impact in expanding use of service and enhancing the quality and quantity of ante- and post-natal care given by TBAs, as well as improving delivery and family planning services and some primary health care skills. In 1991 alone, trained TBAs provided 40,638 ante-natal and 39,586 post-partum visits, supervised 18,350 deliveries, and sold over 60,000 contraceptive supplies. Referrals to MOH facilities numbered more than 14,000.

In the opinion of the evaluation team, funding and technical assistance should be provided to the NTBA for training an additional 3,000 TBAs and reinforcing the skills of previously trained TBAs. The NTBA should evaluate training and improve the process of needs assessment, job analysis, planning of training, materials, and management support systems development. MOH regional and district health teams should assume direct responsibility for implementing the TBA program, with support from the NTBA.

Work needs to be done on strengthening the training and supervision of TBAs. Referral skills of TBAs with regard to high-risk mothers should be improved and more focus should be given to family planning in the training process. The NTBA should concentrate more fully on its role as technical and advisory unit to the MOH. Management systems should be strengthened in order to allow the NTBA to better plan, monitor and evaluate national TBA activities. The future NTBA program should emphasize long-term sustainability of TBA activities by developing NTBA and MOH core capability to continue program management and monitoring.

costs

I. Evaluation Costs

1. Evaluation Team		Contract Number OR TDY Person Days	Contract Cost OR TDY Cost (U.S. \$)	Source of Funds
Name	Affiliation			
Rose M. Schneider	POPTECH	DPE-3024-Z-00- 8078-00	\$90,000	Mission Buy-In.
Tom Coles, Jr.	"			
Margaget Price	"			
2. Mission/Office Professional Staff Person-Days (Estimate) <u>21</u>		3. Borrower/Grantee Professional Staff Person-Days (Estimate) <u>90</u>		

b

A.I.D. EVALUATION SUMMARY - PART II

SUMMARY

J. Summary of Evaluation Findings, Conclusions and Recommendations (Try not to exceed the three (3) pages provided)

Address the following items:

- Purpose of evaluation and methodology used
- Purpose of activity(ies) evaluated
- Findings and conclusions (relate to questions)
- Principal recommendations
- Lessons learned

Mission or Office:

USAID/GHANA

Date This Summary Prepared:

October 7, 1992

Title And Date Of Full Evaluation Report: June 23, 1992

Final Evaluation of the Ghana National
Traditional Birth Attendant Program.

Purpose of Evaluation and Methodology Used

Purpose

- assess progress-to-date under the project grant agreement
- evaluate the validity of the original design and assumptions
- estimate the impact of program activities
- determine lessons learned for follow-on project

Methodology

- reviewed the training process, management systems, materials and methodology used in the NTBA Program
- reviewed pertinent documents and the job analysis
- held discussions with NTBA MOH regional and district staff
- interviewed trainers, master trainers, and TBAs and observed their simulated performances

Purpose of Project

- establish a national secretariat to coordinate, monitor, support, and evaluate a TBA program, using national guidelines
- develop a support system for trained TBAs, including supplies, supervision, record-keeping, referral, and refresher training
- provide information on the project to pertinent health personnel and the target communities
- select and train TBA training coordinators in the Upper West, Volta, Northern, Brong-Ahafo, and Central regions
- identify, select and train up to eight master TBA trainers and TBA trainers from Level B in each of the five regions
- provide necessary support for Level B trainers to train a minimum of ten TBAs in each region for a total of 600 TBAs
- implement and complete training of TBAs in five of Ghana's ten regions selected according to established criteria
- assist master and Level B trainers to establish and maintain an inventory on training, performance and services provided

Principal Project Accomplishments

- founding of a national secretariat
- establishment of a uniform support system for training TBAs
- appropriate orientation of health personnel and communities on the program and its purpose
- training provided to 63 master trainers, 307 TBA trainers, and 3,173 TBAs
- establishment and maintenance of an inventory that is reported monthly by region, and summarized annually by NTBA

Major recommendations**Clinical Services:**

1. Clinical training and supervision should be strengthened to improve the quantity and quality of care given by TBAs. Additional emphasis should be placed on post-natal care and family planning promotion and sales.
2. The nurse midwife curricula and NTBA training for MOH trainers should be enhanced in post-natal care and FP promotion.
3. TBA sales of FP supplies and ORS should be monitored and analyzed. Additional training and development of supply systems will be needed if sales include oral contraceptives.
4. The MOH system for return referral to TBAs should be enhanced to assure continuity of care; analysis of TBA reporting form returns should be strengthened to ensure that at risk mothers receive appropriate care.
5. The referral criteria for high risk women should be periodically reviewed and referrals monitored to assure the continued capability of the MOH to care for high-risk women. **Mission comment: the Mission is more concerned about ensuring that high-risk women can be efficiently transferred from TBAs into the MOH system then increasing tertiary capacity to care for high-risk births.**

Training

1. An NTBA/MOH core capability for training and supervision should be developed at the programmatic level, using a competency-based teaching/learning model.
2. A plan for institutionalizing training and developing and strengthening a core capability of competent MOH trainers, supervisors, and NTBA facilitators should be established.
3. Training methodology and content revisions for future training should be incorporated into the supervisory retraining of MOH master trainers, trainers, and trained TBAs. The initial emphasis of the future NTBA Program should be on the upgrading

- of TBA and trainer skills through in-service education.
4. Collaboration with the MOH/MCH division is needed to assure that changes in official norms are included in NTBA training.
 5. The NTBA should revise and develop additional NTBA/MOH training materials for trainers and TBAs, based on an assessment of community health needs. Increased hands-on training should be stressed.
 6. A process for monitoring and evaluating training and materials should be established.

Management

1. The NTBA should function as a technical and managerial advisory unit to the MOH. It should plan, manage, monitor, and evaluate the future NTBA program and advise the MOH RHMTs and the DHMTs. Technical assistance and short-term training should be planned to strengthen core NTBA staff capability to assume these expanded functions.
2. The HIS system should be standardized and strengthened to assure collection and analysis of simple useful data items. Family Planning referral data should be added. Coordination with MOH MCH and other related HIS efforts are needed. The emphasis of the HIS system should be on regular analysis and use of NTBA data for decision making at all levels.
3. The drug and medical supplies systems should be reviewed to ensure a consistent supply of high-quality supplies to TBAs. Sales data should be analyzed for trends in use. Coordination between NTBA and the MOH is needed in the monitoring of sales data generated to assure regular trend analysis of use.
4. The communications system should be formalized to incorporate regional and district health directors. This would increase their ownership of the NTBA program.
5. The referral system should be reviewed to assure two-way MOH-TBA referral and continuity of care. Enhancing this system will require the orientation of MOH Staff at all levels.
6. Small OR studies should be carried out at the regional and district levels to test adaptations of clinical, training, and management approaches appropriate to local conditions.
7. The proposed organizational structure, with new and expanded NTBA responsibilities to plan, develop, monitor, and evaluate the future NTBA program should be implemented.

ATTACHMENTS

K. Attachments (List attachments submitted with this Evaluation Summary; always attach copy of full evaluation report, even if one was submitted earlier; attach studies, surveys, etc., from "on-going" evaluation, if relevant to the evaluation report.)

COMMENTS

L. Comments By Mission, AID/W Office and Borrower/Grantee On Full Report

Lessons Learned

It should be noted that the evaluation did not contain a section on lessons learned. The following points were inferred from the text of the report.

1. Undertaking an effective and appropriate training of TBAs can have a significant positive impact on increasing the quantity and quality of care given to women and infants.
2. The caliber of training and supervision offered to TBAs and their trainers impacts directly on the quality and quantity of the clinical care they give and their level of motivation. To see a higher and more comprehensive quality of care, further emphasis needs to be placed on training development and an increase in the frequency and quality of supervision.
3. The training given to TBAs is focused on normal deliveries and on mothers who are not considered at risk. More emphasis should be placed on how to handle complications at birth (i.e., wrapped cord or breech presentation) and the appropriate referral of high-risk mothers.
4. Dialogue at the community level on continued and increased support that will lead to long-term sustainability of TBA activities is a vital component of the NTBA Program. Additional TBAs should be identified in each community to assure continuous access to trained TBAs.
5. The appropriate development of training and materials should be based on an in-depth job analysis rather than on a general job description.
6. Training development should be formally structured and developed to assure that master trainers and trainers acquire the skills needed to plan and implement training and follow-up supervision.
7. The NTBA needs to focus more fully on its broader role of serving as technical and management advisor to the MOH to ensure that needed attention is given to developing and managing the various systems that support the program such as HIS and the drug and supply, referral, equipment and other management systems.

XD-ABF-151-A
ISN 80513

Prepared for

USAID/Accra
Under PIO/T No. 641-0109-3-60012
and Office of Population
Bureau for Research and Development
Agency for International Development
Washington, D.C.
under Contract No. DPE-3024-Z-00-8078-00
Project No. 936-3024

**FINAL EVALUATION OF THE GHANA
NATIONAL TRADITIONAL BIRTH
ATTENDANT PROGRAM**

by

Rose M. Schneider
Tom Coles, Jr.
Margaret Price

Fieldwork
March 16 - April 22, 1992

Produced by

Population Technical Assistance Project
DUAL Incorporated and International Science
and Technology Institute, Inc.
1601 North Kent Street, Suite 1014
Arlington, Virginia 22209
Phone: (703) 243-8666
Telex: 271837 ISTI UR
FAX: (703) 358-9271

June 23, 1992

Table of Contents

Glossary	v
Project Identification Data	vi
Executive Summary	viii
1. Introduction	1
1.1 Evaluation	1
1.1.1 Purpose of Evaluation	1
1.1.2 Scope of Work	1
1.2 Program Background	2
1.3 NTBA Program Accomplishments	4
1.4 Summary of Recommendations	5
1.4.1 Clinical Services	5
1.4.2 Training	6
1.4.3 Management	7
2. Clinical Impact	8
2.2 Impact on Services Utilization	9
2.2.1 Antenatal Clients and Visits	10
2.2.2 Supervised Deliveries	11
2.2.3 Post-Natal Clients and Visits	11
2.2.4 Sales of Family Planning and ORS Supplies	11
2.2.5 Referrals to MOH Facilities for Antenatal Care, Delivery	12
2.3 Impact on the Quality of Care Provided	12
2.3.1 Antenatal Care	12
2.3.2 Birth and Delivery	13
2.3.3 Post-Partum Care	14
2.3.4 Family Planning	15
2.3.5 Referrals	16
2.3.6 PHC Skills	17
2.3.7 TBA Care and Referral of At-Risk Women	17
2.3.8 Tetanal Immunizations	18
2.4 Impact of NTBA Program on Perceptions of TBAs	18
2.4.1 TBA Self-Perceptions (Morale and Performance)	18
2.4.2 Community and Client Perception of TBAs	19
2.5 Unmet Needs (Other Clinical Issues)	20

3.	Training Systems Review and Assessment	21
3.1	Overview	21
3.1.1	Evaluation Methodology	21
3.1.2	Accomplishments	21
3.2	Development of NTBA and MOH Core Training Capability	22
3.3	Training Development Process Assessment	23
3.3.1	Assessment of Community Health Needs	24
3.3.2	Job Analysis	24
3.3.3	Assessment of Learning Needs and Plan Training	25
3.3.4	Establishment of Management Support Systems	26
3.3.5	Development of Training Materials	26
3.3.6	Implementation of Training	28
3.3.7	Monitoring and Evaluation of Program	28
4.	Management Review and Analyses	29
4.1	Overview	29
4.1.1	Methodology	29
4.1.2	NTBA Program Management Systems Needs	29
4.2	Organizational Structure and Personnel	29
4.3	NTBA Program Within the Context of Other MOH Reorganization Activities	31
4.4	Health Information Systems	32
4.5	Drugs and Medical Supplies Systems	34
4.6	Referral Systems	35
4.7	Equipment and Supplies System	36
4.8	Communications System	37
4.9	Program Planning, Monitoring and Evaluation System	37
4.10	Structure and Responsibilities for the Future NTBA Program	39
5.	Comparison of USAID-Supported with Other Donor Supported Regions	42
6.	Operations Research	43
7.	Sustainability Issues	44
7.1	Financing Mechanisms and Channels	44
7.2	Institutionalization for Sustainability	44
7.3	Community Participation for Sustainability	45

List of Tables and Figures

Table 1	Ghana TBA: Original Objectives and Current Achievements	3
Table 2	Quantity and Comparison of 1990 & 1991 NTBA Reported Services in Five USAID Funded Program Regions	10
Table 3	Referrals of Women at Risk in Five Project Areas	18
Figure 1	Training Development Process	24
Figure 2	Current National TBA Program	30
Figure 3	NTBA Health Information System	33
Figure 4	NTBA Referral System	36
Figure 5	NTBA Communications System	38
Figure 6	Proposed NTBA Reorganization	41

List of Appendices

- Appendix A The Evaluation**
 - Team Scope of Work
 - Summary of Questions
 - Team Composition
 - List of Documents Reviewed
 - List of Contacts
 - Map of Ghana

- Appendix B Clinical**
 - Focus Group Discussion Summaries
 - TBA Kit

- Appendix C Training**
 - NTBA Job Analysis
 - Competency-based Learning Model
 - Skills Checklist - Learning Objectives
 - Mastery Learning Plan

- Appendix D Management**
 - Indicators for Management of Future NTBA Program Development
 - Scope of Work for ACNM
 - NTBA Program Action Plan

Glossary

ACNM	American College of Nurse Midwives
ANC	antenatal care
CNM	Community Nurse Midwife
DHMT	District Health Management Team
DMO	District Medical Officer
FP	family planning
GOG	government of Ghana
HB	hemoglobin
HIS	health information system
IEC	information, education and communication
KAP	knowledge, attitude and practice
MCH	maternal and child health
MIS	management information system
MOH	Ministry of Health
MFEP	Ministry of Finance and Economic Planning
NGO	non-governmental organization
NO	Nursing Officer
NTBA	National Traditional Birth Attendant
OR	operations research
ORS	oral rehydration solution
ORT	oral rehydration therapy
PHC	primary health care
PHN	Public Health Nurse
PIO/T	project implementation order/technician
PNC	post-natal care
PNO	Principal Nursing Officer
REDSO/WCA	Regional Economic Development Services Office/West and Central Africa
RHMT	Regional Health Management Team
RMO	Regional Medical Officer
SOW	scope of work
SSS	sugar/salt solution
TA	technical assistance
TBA	Traditional Birth Attendant
TOT	training of trainers
USAID	U.S. Agency for International Development (mission)

Project Identification Data

1. **Scope:** Ghana
2. **Project Title:** National Traditional Birth Attendants Program
3. **Project Number:** 641-0462-41
4. **Grant Number:** AFR-0462-G-SS-8049-00
5. **Critical Project Dates:**
Grant Agreement Signed: April 1989
Project Assistance Completion Date: June 30, 1992
6. **Project Funding:**

Grant Agreement	\$671,140
FHI-II 698-0462.41	\$313,155
USAID Buy-In	\$680,573
Total Obligated Amount	\$1,664,868

Funding for additional components: Columbia University -
DPE-3030-A-99-4049-00
7. **Mode of Implementation:** Grant Agreement between A.I.D./W,
REDSO/WCA and ACNM.
8. **Grantee:** American College of Nurse Midwives Special
Projects Section, Washington, D.C.
9. **Major Activities:**

To establish an office at the national level to coordinate, monitor, support and evaluate a TBA program, using national guidelines.

To implement a TBA program in phases by selecting 5 regions using a set of criteria.

To further develop a uniform and workable support system for trained TBAs to include supervision, supplies, record keeping and referral in each of the 5 regions selected:

 - a) To orient health personnel and community to the program.
 - b) To identify, select and prepare up to eight master trainers.
 - c) To identify, select and prepare up to sixty TBA trainers from Level B posts.

- d) To support TBA trainers in training 10 TBAs each for a total of 600 TBAs per region.
- e) To assist Master TBA trainers to establish and maintain an inventory of TBAs and health facilities (both governmental and NGOs) involved in TBA activities.

Executive Summary

In 1989, the Ghana National Traditional Birth Attendant (NTBA) Program grant was awarded for three years between the Agency for International Development's (A.I.D.) Regional Economic Development Services Office/West and Central Africa (REDSO/WCA) and the America College of Nurse Midwives (ACNM). This grant provided technical assistance and support to establish the NTBA office to coordinate, monitor, support and evaluate a national traditional birth attendant program in five Ministry of Health (MOH) regions. The NTBA program was funded to assist the MOH to expand its primary health care services to rural areas. The NTBA Project was to assist the MOH to identify, train and support traditional birth attendants and their trainers to provide antenatal, delivery, postnatal care and family planning services to their rural communities.

The NTBA grant activities were built upon the 1978 MOH policy paper position which established the traditional birth attendant as the key provider of maternal child health services in rural areas and as a potential provider of additional primary health care services. A pilot TBA operations research program conducted by the MOH with the assistance of Columbia University provided the MOH with the experience base to establish national TBA guidelines to train and support a national program and to seek support from international donors.

The NTBA Secretariat in 1989 operationalized the national NTBA training and support activities working in coordination with the Maternal Child Health and Manpower and Training divisions at the MOH central level and with regional and district health teams in the 10 MOH regions.

Clinical Issues

The NTBA Program has had a considerable positive impact in increasing the quantity and quality of clinical care of Ghanaian women and infants. Impact can be seen in areas of utilization of services and in the quality and quantity of care given by TBAs in antenatal and post-natal care, delivery, family planning, and some primary health care (PHC) skills. Community and client confidence in the TBA has increased and the attitudes of health professionals toward the NTBA-trained TBAs have also improved.

NTBA service data for 1990 and 1991 were analyzed for the five NTBA regions assisted under the project funded by the U.S. Agency for International Development (USAID) being evaluated in this report. In 1991, trained TBAs provided some 40,638 antenatal and 39,586 post-partum visits, supervised 18,350 deliveries, and sold over 60,000 family planning supplies (condoms and vaginal tablets). Referrals to MOH facilities numbered more than 14,000 in 1991. Additionally, thousands more women and infants receive services from NTBA-trained TBAs in the five regions funded by other donors.

Quality of care given by trained TBAs was assessed by simulated clinical skills assessments in antenatal care, delivery, post-natal care and family planning. The antenatal care assessment showed high levels of competence, with over 80 percent of TBAs performing the required antenatal skills of hand washing, examination of the women, and checks for anemia and providing appropriate health education and referral. Delivery skills measured by a knowledge, attitude and practice (KAP) survey found high skill levels in the areas of hygiene, preparation of the women, and knowledge of signs of emergency and need for referral. Little difference was noted between trained and untrained TBAs, however, when it came to handling complications such as a wrapped cord or breech presentation.

Executive Summary

In 1989, the Ghana National Traditional Birth Attendant (NTBA) Program grant was awarded for three years between the Agency for International Development's (A.I.D.) Regional Economic Development Services Office/West and Central Africa (REDSO/WCA) and the America College of Nurse Midwives (ACNM). This grant provided technical assistance and support to establish the NTBA office to coordinate, monitor, support and evaluate a national traditional birth attendant program in five Ministry of Health (MOH) regions. The NTBA program was funded to assist the MOH to expand its primary health care services to rural areas. The NTBA Project was to assist the MOH to identify, train and support traditional birth attendants and their trainers to provide antenatal, delivery, postnatal care and family planning services to their rural communities.

The NTBA grant activities were built upon the 1978 MOH policy paper position which established the traditional birth attendant as the key provider of maternal child health services in rural areas and as a potential provider of additional primary health care services. A pilot TBA operations research program conducted by the MOH with the assistance of Columbia University provided the MOH with the experience base to establish national TBA guidelines to train and support a national program and to seek support from international donors.

The NTBA Secretariat in 1989 operationalized the national NTBA training and support activities working in coordination with the Maternal Child Health and Manpower and Training divisions at the MOH central level and with regional and district health teams in the 10 MOH regions.

Clinical Issues

The NTBA Program has had a considerable positive impact in increasing the quantity and quality of clinical care of Ghanaian women and infants. Impact can be seen in areas of utilization of services and in the quality and quantity of care given by TBAs in antenatal and post-natal care, delivery, family planning, and some primary health care (PHC) skills. Community and client confidence in the TBA has increased and the attitudes of health professionals toward the NTBA-trained TBAs have also improved.

NTBA service data for 1990 and 1991 were analyzed for the five NTBA regions assisted under the project funded by the U.S. Agency for International Development (USAID) being evaluated in this report. In 1991, trained TBAs provided some 40,638 antenatal and 39,586 post-partum visits, supervised 18,350 deliveries, and sold over 60,000 family planning supplies (condoms and vaginal tablets). Referrals to MOH facilities numbered more than 14,000 in 1991. Additionally, thousands more women and infants receive services from NTBA-trained TBAs in the five regions funded by other donors.

Quality of care given by trained TBAs was assessed by simulated clinical skills assessments in antenatal care, delivery, post-natal care and family planning. The antenatal care assessment showed high levels of competence, with over 80 percent of TBAs performing the required antenatal skills of hand washing, examination of the women, and checks for anemia and providing appropriate health education and referral. Delivery skills measured by a knowledge, attitude and practice (KAP) survey found high skill levels in the areas of hygiene, preparation of the women, and knowledge of signs of emergency and need for referral. Little difference was noted between trained and untrained TBAs, however, when it came to handling complications such as a wrapped cord or breech presentation.

Most (92 percent) of trained TBAs performed well in general post-partum skills, breast exam, providing advice on nutrition, and referral for immunization. Overall, however, TBAs' post-partum skills are not strong, with hygiene and physical exam of the women being done on only about half of the cases.

In caring for the infants, trained TBAs used hygienic practices when handling the infant and providing cord care. Almost all trained TBAs promoted breastfeeding and introduction of solid food. Their advice, however, was sometimes incorrect and inconsistent.

Trained TBAs were generally not strong in family planning (FP) counseling skills, but they could provide clear and correct information on the two methods that they sold. Seventy percent of clients reported that the TBA had provided them with FP information and half stated that had heard about FP first from a TBA. TBAs had much less knowledge about pills, injections, and other methods. Almost all trained TBAs referred clients to the MOH for FP services.

Funding and technical assistance should be provided to the NTBA for a future program of training and support for TBAs. The program should train an additional 3,000 TBAs and reinforce the training and support of the TBAs previously trained during this program.

Strengthening the training and supervision of TBAs is needed. Reinforcement of skills for normal pregnancies and deliveries should be strengthened. The emphasis should be on skills in the identification and appropriate referral of complications of antenatal, delivery and post-natal conditions. Increasing the frequency and quality of the supervision should receive emphasis to motivate TBAs and increase the skills, especially in post-partum care and FP and nutrition. Additional hands-on training and practice should be provided.

Close coordination of the NTBA with the MOH is needed to define and revise protocols for TBA care, i.e., for addition of sales of oral contraceptives, etc. Coordination of the increased referrals generated by TBAs will also be important. Increased NTBA and MOH emphasis should be placed on referral of high-risk women for care at health facilities.

Dialogue at the community level on continued and increased support that will lead to long-term sustainability of TBA activities should be continued as a vital component of the NTBA Program. Additional TBAs should be identified in each community to assure continuous access to trained TBAs.

Training

The NTBA training component was successful in accomplishing a number of training objectives. The NTBA, working with the MOH, trained more than 3,000 TBAs, 307 trainers, and 63 master trainers to a basic level of competency. TBAs were trained adequately in simple skills, particularly in the area of normal deliveries. TBAs generally did not master more complex skills in the areas of ante- and post-natal care and FP. This appeared related to lower TBA motivation in these areas and less emphasis on these skills during training. Trainers generally tested lower in these same areas.

NTBA training emphasis was on achieving numerical targets for TBAs trained; development of core capability of NTBA facilitators and the capability of trainers to plan, develop and implement training received less emphasis. The process of training development was not formally structured and

developed. The process and length of training of master trainers and trainers were not sufficient for them to master skills needed to plan and implement training and follow-up supervision.

Skills practice was usually in a classroom setting. There was relatively little hands-on training. The TBAs reported positively on supervision and support from the MOH. There is a need, however, to structure supervision to assure continued high TBA performance.

NTBA training materials developed provided a foundation for training, but presentation was mixed and several important omissions in content were noted. The training and materials development was not based on an in-depth job analysis. Instead it was based on a general TBA job description.

The NTBA should upgrade skills for trainers and TBAs by using competency-based methodology, beginning with upgrading those trainers and TBAs already trained. This will allow the NTBA to develop all steps of the training development process, pair trained with untrained trainers and TBAs to upgrade those previously trained while, at the same time, beginning the training process for the initial training of 3,000 additional TBAs, their trainers and master trainers for the future program.

The NTBA should strengthen and formalize the process of needs assessment, job analysis, planning of training, materials, and management support systems development, as well as establish the process to evaluate training for revision and improvement.

Management

The NTBA initiated and developed its program focusing considerable effort on initiating the training for thousands of TBAs and expanding their services to clients. The NTBA did not place equal emphasis on the establishment and strengthening of management systems to support program efforts and ensure sustainability.

The current NTBA organizational structure gives the NTBA a direct responsibility for implementation of training, supervision and support. This is not in keeping with the broader role of the NTBA, which is to serve as technical and management advisors to the MOH. It is the MOH Regional and District Health Management Teams (RHMT and DHMT) that have the responsibility for training, supervising and supporting TBAs. NTBA staff were active in initiating training activities. They did not, however, emphasize activities related to developing and managing the various systems that support the NTBA program such as the health information system (HIS) and the drug and supply, referral, equipment and other management systems.

Assessment of the HIS found a moderate level of collection of valuable TBA data but little routine analysis by NTBA or the MOH or use of this data in decision making. Information generally flowed to the MOH with little feedback to the TBAs, negatively affecting continuity of care.

Review of the drug and supply system found that a parallel system of supplies flowed through the maternal and child health (MCH) nursing channels with little participation of MOH pharmacists. This was due to previous training and constant availability of nursing staff. Supply and sales data were generally not monitored on a regular basis, sometimes resulting in gaps in availability. To assure continuity of supplies, especially with the proposed addition of oral contraceptives to TBAs, NTBA strengthening of this system is needed.

Findings about the referral systems were similar to those for the HIS system, with information flow from the TBA to MOH staff and little return of information to the TBA. Both an official and an unofficial NTBA communication system were in operation. Although short-term results were gained through this parallel system, the longer-term benefits of full involvement of the RHMTs and the DHMTs were not fully realized. Operations research (OR) conducted before the program's start provided the information base for uniform program development. Future OR approaches are planned to use smaller studies to test local interventions and adaptations to the model.

There was not a formal NTBA system to plan, monitor, and evaluate the program and an NTBA program plan, annual NTBA plans, and MOH regional plans were not developed. These should have been created to provide structure within which to develop NTBA management systems. It was noted that the original seven program objectives did not include the planning of the NTBA program.

Program activities in USAID-funded regions were compared with those of other donors. In general, USAID funding was provided sufficiently in advance and with continuity to allow NTBA and the regional level MOH to function effectively. Donor funding of the Strengthening District Health Management Initiatives by WHO provided core epidemiological and management skills which allowed DHMTs to more effectively implement the NTBA program.

Sustainability issues were assessed, addressing the appropriate approach to channeling future USAID funding to balance the NTBA program schedule with long-term sustainability needs.

The proposed new organizational structure should be implemented to establish NTBA as a strong technical and management advisory unit to the MOH.

Management systems should be strengthened to improve NTBA ability to plan, monitor and evaluate national TBA activities. MOH regional and district health teams should assume direct responsibility for the implementation of the TBA program, with support from the NTBA. NTBA health information, referral, communications, and other management systems should be strengthened and coordinated with MOH systems to assure continuity of services. Management technical assistance should be provided by international and Ghanaian advisors as described in the comprehensive scope of work and draft program plan.

The future NTBA program should emphasize long-term sustainability of TBA activities by developing NTBA and MOH core capability to continue program management and monitoring. In addition, communities should be stimulated to actively contribute and participate in decision making and support of TBAs to ensure local ownership and long-term sustainability.

1. Introduction

1.1 Evaluation

1.1.1 Purpose of Evaluation

The principal purpose of this evaluation is to provide guidance for the implementation of the follow-on National Traditional Birth Attendant (NTBA) program, which will continue support for the Traditional Birth Attendants (TBA) and program activities already initiated and will expand the training, supervision, support, and management of the NTBA/Ministry of Health (MOH) Program for an additional 3,000 TBAs.

The evaluation will assess the program progress to date, including the validity of the original design and assumptions. It will assess the impact of program activities on the work of the TBAs and their clients, and address the lessons learned in the clinical, training and management areas.

1.1.2 Scope of Work

The Scope of Work (SOW) provided comprehensive guidance to the evaluation team (see Appendix A). The SOW directed the evaluators to assess the following major areas:

Clinical Services

Assess the clinical impact of TBA performance supported by the NTBA program. Review clinical content of the NTBA curriculum for accuracy and appropriateness. Assess additional clinical skills needed by TBAs for future expanded primary health care (PHC) responsibilities.

Training

Evaluate the training aspects of the NTBA Program; specifically, review NTBA curriculum and teaching methods and evaluate content, appropriateness and completeness, review NTBA/MOH teaching methods and evaluate their effectiveness. Finally, review knowledge of NTBA master trainers, trainers of trainers, and trainers to determine how well they have learned and are able to implement NTBA program objectives.

Management

Assess all management issues of the program – specifically, the organization and functioning of the NTBA and the relationship of the NTBA to the MOH at the central, regional, and district levels. Evaluate structure and effective functioning of management systems, including record keeping, both activity and financial, which supports the NTBA program. Because an audit was being carried out,

the evaluation team was directed not to include financial systems in the management assessment.

In addition to this report and its appendices, the evaluation team provided the mission with several addenda to this report (see Appendix A for further details on the assignment).

1.2 Program Background

The current NTBA program is built upon a number of MOH policies and programs. In 1978, the MOH Primary Health Care Policy Paper recognized the role of the TBA as the key provider of maternal and child health (MCH) services in rural areas and her potential to provide additional services (oral rehydration solution [ORS] and Family Planning [FP]). Since the early 1970s, TBAs had been trained by a number of different agencies and the MOH. In 1986, the MOH with several donors developed a uniform approach to the training and support of TBAs with the technical assistance of the American College of Nurse Midwives (ACNM). In 1987, the MOH, with the technical assistance of Columbia University, developed an operations research (OR) project to provide guidance on the development of the structure, management, training, and clinical aspects of the TBA program. Information from these pilot efforts helped the MOH to establish national guidelines for the TBA program and guidance to develop methodologies and materials for the training and support of a nationwide TBA program.

In September 1988, the ACNM received a centrally funded Family Health Initiatives grant from A.I.D./Washington (No. 0462-G-SS-9049-00) to provide technical assistance to improve the provision of family planning services by midwives. One of the two major objectives of this program was to increase the ability of the TBAs to provide MCH/FP services. A grant was also awarded to the ACNM through the USAID/Ghana Contraceptives Supplies project (No. AFRO 462-G-SS-8031-00) with a similar aim to train TBAs to provide PHC services including family planning services in rural areas. The chronology of agreements has been included in the ACNM Program Summary prepared in March 1992. The three-year project was initiated in April 1989.

The ACNM provided technical assistance to the MOH for the creation and support of the NTBA secretariat to provide guidance for the MOH's nationwide TBA program, the development of training and support of TBA activities in five regions supported by USAID funding. This Program supported the training of more than 3,000 TBAs, 307 trainers, and 63 master trainers and supports their ongoing supervision. The TBA training methodologies and materials developed under the USAID project are used nationwide, i.e., in regions that received TBA program support from other donors.

Table 1

Ghana TBA: Original Objectives and Current Achievements

Project Objectives	Accomplishments to date
To establish a national secretariat to coordinate, monitor, support and evaluate the TBA training program against specific national guidelines	Established.
To develop a uniform and workable support system for trained TBAs which includes supervision, supplies, record-keeping, referral and refresher training	Uniform support system is established and includes: <i>NTBA Program Guidelines, rev. 6/89; Trainers' Manual for the Training of TBAs in Ghana, 2/90; Manual for the Training of TBAs in Ghana, Vol. I-III, 9/88</i>
To orient health personnel and the communities concerned with the program and its purpose	Health personnel (especially at Level B) and communities have been oriented to the program and those interviewed could correctly explain the overall goal of the program
To select and train TBA training coordinators in the Volta, Northern, Upper West, Brong-Ahafo and Central Regions	Training coordinators in all five A.I.D.-supported regions selected and trained
To identify, select and train up to eight master TBA trainers in each of the five regions	Sixty three (63) Master Trainers have been trained
To identify, select, and train up to sixty TBA trainers from Level B (Health Center Level) in each of the five regions	Three hundred and seven (307) TBA trainers have been trained
To provide all necessary financial and material support for each Level B trainer to train a minimum of ten TBAs (minimum total to 600 TBAs have been trained per region)	Financial and national support provided for training
To implement and complete training of TBAs in five of Ghana's ten regions which have been selected based on established criteria	Three thousand, one hundred and seventy three (3,173) TBAs have been trained
To assist master trainers and Level B TBA trainers to establish and maintain an inventory of TBAs in their respective areas, with information on the TBAs' current status, training, performance and the services they provide	A TBA inventory was established with information on the TBAs current status, training, performance and service being reported monthly by region and is summarized annually by NTBA

1.3 NTBA Program Accomplishments

The NTBA Program was found to be fundamentally sound. The NTBA has achieved the following against the program objectives (see Table 1 below). The MOH established the NTBA Program in April 1989. It was supported by MOH/USAID funding and implemented in phases in five MOH regions - Volta, Northern, Upper West, Brong Ahafo, and Central. It has been implemented in the remaining five regions by the MOH with funding support from other donors.

A uniform support system for training TBAs has been established. Training materials developed include

- National Traditional Birth Attendants Program Guidelines, revised June 1989
- Trainers' Manual for the Training of TBAs in Ghana, February 1990
- A Manual for the Training of TBAs in Ghana, Volumes I-III, September 1988.

In the five NTBA regions supported by USAID

(a) Health personnel (especially those at Level B) and communities have been oriented to the program and those interviewed could correctly explain the overall goal of the program.

(b) Sixty-three (63) master trainers have been trained.

(c) Three hundred and seven (307) TBA trainers have been trained.

(d) Three thousand, one hundred and seventy three (3,173) TBAs have been trained.

(e) A TBA inventory was established, is maintained, is reported monthly by region, and is summarized annually by NTBA.

The training process established a foundation on which to build a competency-based teaching/learning methodology and developed some basic training competencies in trainers.

Other accomplishments of the NTBA program include

- The NTBA established the trained TBA as a key community-based MCH and family planning service provider in Ghana.
- The NTBA program legitimized the role of the trained TBA in the eyes of health service providers.
- The NTBA methodology used encouraged active community participation in assessing needs, involvement, and contribution to meeting needs, as well as program ownership.

- NTBA training and supervision improved working relationships and mutual understanding and respect between trained TBAs and community members and MOH and non-governmental organization (NGO) service providers.
- The training process motivated trained TBAs to share what they have learned with others, including training other TBAs on their own initiative. NTBA promoted the concepts and principles of adult learning.
- Nationwide NTBA management systems and processes were initiated to train and support TBAs in 10 regions.
- Service delivery data were generated to quantify value of trained TBA to clients and communities.

1.4 Summary of Recommendations

1.4.1 Clinical Services

- 1) The NTBA should strengthen clinical training and supervision to improve the quantity and quality of clinical care given by TBAs and their trainers. NTBA should improve training and supervision to improve TBA skills in antenatal, delivery and post-natal care and family planning promotion and sales. While emphasis should be placed on proper clinical care of normal pregnancies, the NTBA should also improve TBA skills in identification of complications of pregnancy and delivery for care and appropriate referral. NTBA and the MOH should jointly define the role of TBAs in care of complications.
- 2) The NTBA and MOH should review and strengthen the NTBA clinical curricula and supervisory guides for improved antenatal, delivery, post-natal care and family planning. Additional emphasis should be placed on post-natal care and family planning promotion and sales for retraining of trained TBAs and initial training of additional thousands of TBAs.
- 3) NTBA and the MOH should review and strengthen the nurse midwife curricula and NTBA training for MOH trainers especially in post-natal care and family planning promotion. NTBA and MOH should strongly consider incorporating into TBA training information and skills for oral contraceptive promotion and for identification and care of anemia and malnutrition.
- 4) The NTBA should monitor TBA sales of FP supplies and ORS with analysis of the monthly TBA returns. Additional training and support and development of supply systems will be needed if the TBAs expand their sales to include oral contraceptives.
- 5) The NTBA and the MOH should continue to encourage TBAs to refer women, especially those at risk, for services. The MOH system for

return referral to TBAs should be strengthened to assure continuity of care of the women and recognition of the TBAs. NTBA and MOH analysis of TBA reporting form returns should be strengthened to assure that the high number of at risk mothers receive appropriate care. The issue of TBAs' continuing to deliver high-risk mothers should be examined by NTBA and MOH/MCH to consider additional motivation/training of TBAs to refer these women. Emergencies, however, must always be taken into account.

6. Since a relatively high percentage of women are apparently at high risk, and increased referrals may strain the MOH MCH capacity to provide care, the NTBA should monitor increased numbers of referrals and the NTBA/MOH should jointly review norms. The NTBA and MOH should periodically review referral criteria to assure continued capability of the MOH to receive and care for high-risk women.

1.4.2 Training

- 1) An NTBA/MOH core capability for training and supervision should be established and developed, using a competency-based teaching/learning model. This should be used for all future training and retraining at NTBA. This systematic process for training development should be developed, documented and followed at the programmatic level.
- 2) An affordable and sustainable plan to institutionalize training and develop and strengthen a core capability of competent trainers/supervisors, NTBA facilitators, and MOH trainers within the MOH should be developed and implemented.
- 3) Technical assistance, both international and Ghanian, in the competency-based learning model should be provided to facilitate this process. A strategy for implementing the following recommendations is outlined in the plan of action (see Appendix C).
- 4) Revisions to the training methodology and content for all future training, revised antenatal care, delivery, PHC, FP and other components, should first be incorporated into the supervisory retraining of MOH master trainers, trainers, and trained TBAs. The initial emphasis of the future NTBA Program should be on the upgrading of previously trained trainers and TBAs through in-service education. With improved skills, the training of additional trainers and TBAs can take place.
- 5) Full collaboration with the MOH/MCH division should be done needed to assure that any changes in official norms are included into the NTBA training.
- 6) The NTBA should revise and develop additional NTBA/MOH materials for the training and support of trainers and TBAs. This should include strengthening and documenting the process including for basic health messages. Development of training and materials

should be based on a firm assessment of community health needs. Increased hands-on training should be stressed.

7) A process for monitoring and evaluation of training and materials development should be developed.

1.4.3 Management

1) The NTBA should function as a technical and managerial advisory unit to the MOH. It should plan, manage, monitor, and evaluate the future NTBA program and advise the MOH RHMTs and the DHMTs, which have the responsibility for program implementation.

2) Technical assistance and short-term training should be planned to strengthen core NTBA staff capability to assume these expanded functions.

3) The HIS system should be standardized and strengthened to assure collection and analysis of simple useful data items. FP referral data should be added. Coordination with MOH MCH and other related HIS efforts are needed. The emphasis of the HIS system should be on regular analysis and use of NTBA data for decision making at all levels.

4) The drug and medical supplies systems should be reviewed to assure a consistent supply of high-quality supplies to TBAs. Sales data should be analyzed for trends in use. Coordination between NTBA and the MOH is needed in the monitoring of sales data generated to assure regular trend analysis of use. Addition of oral contraceptives and other FP and PHC supplies will require additional training and monitoring at all levels.

5) The communications system should be formalized to incorporate regional and district health directors. This would increase their ownership of the NTBA program. Increased sharing of TBA information will also strengthen cooperation and support the future integration of TBA activities within the MOH structure.

6) The referral system should be reviewed to assure two-way MOH-TBA referral and continuity of care. Strengthening this system will require the orientation of MOH staff at all levels.

7) Small OR studies should be carried out at the regional and district levels to test adaptations of clinical, training, and management approaches appropriate to local conditions.

8) The proposed organizational structure, with new and expanded NTBA responsibilities to plan, develop, monitor, and evaluate the future NTBA program, should be implemented. Strong consistent management technical assistance should be provided by ACNM and local management advisors to assist NTBA to expand its capabilities, especially in the area of management systems development.

2. Clinical Impact

2.1 Clinical Assessment

2.1.1 Services Offered by Trained TBAs since Training in USAID-Supported Regions

The NTBA Program has had a considerable positive impact in increasing the quantity and quality of clinical care to Ghanian women and infants. Visible areas of impact of the NTBA program are in the utilization of services, quality and quantity of care of TBAs in antenatal care, delivery, post-natal care, family planning and some PHC skills.

2.1.2 Study Methodology

In addition to the analyses of NTBA statistical records for reported data for the years 1990 and 1991, an in-depth assessment of the impact of the NTBA program was conducted by the clinical skills evaluator in Brong Ahafo and Central regions, 2 of the 5 USAID-supported regions. Findings were augmented by the other team members who interviewed TBAs in two other regions.

A mixture of tools and approaches was used to obtain a comprehensive picture of the TBAs' clinical performance and the perception of this performance by the community, clients and other health workers. Questionnaires, focus groups, clinical practicum, demonstration, observation, and collation and analysis of existing data were performed.

An analysis was conducted of TBA records on an individual and national basis; and the national MOH statistics for key MCH indicators were examined to ascertain whether the TBA input was having any impact on the national picture. Since the training began in 1989, 1989 through 1991 data were used.

Clinical skills in the areas of antenatal care (ANC), post-natal care (PNC), and family planning (FP) were assessed using actual clients and clinical skills checklists developed by the evaluator. These lists were based on the curriculum content. Midwives who had not been involved in the training of TBAs were prepared and used in the application of the checklist. Skills for labor and delivery were assessed using a KAP questionnaire, based again on the curriculum content. This questionnaire was also administered to untrained TBAs and used as basis for comparison of the KAP of trained TBAs. Trained TBAs were also asked to state how they prepared saline and sugar solution (SSS).

Perceptions of community opinion leaders, clients, and other midwives were elicited. Two tools, focus group discussion and structured questionnaires, were used to gather this information. These tools were also used to identify any perceived needs for

change, or currently unmet needs. The reaction of trained TBAs to the training, and its impact on the community and their functioning, were also elicited through the use of focus groups.

Six indicators of utilization and two morbidity/mortality indicators were used. Utilization indicators were antenatal attendances; tetanal immunizations; supervised deliveries; post-natal attendances; infant immunizations; and referrals. Morbidity/mortality indicators were number of live deliveries and perinatal tetanus.

Due to time constraints, the numbers of persons interviewed or tested in the different skill areas varied depending on availability of TBAs and clients. Thus, a total of 44 trained and 32 untrained TBAs completed a KAP questionnaire; 44 trained TBAs gave ANC; 36 gave PNC; and 33 provided counseling on family planning; 60 were asked to explain the procedure for mixing SSS; 17 midwives, medical assistants, and community health nurses who were not involved with the TBA training program were interviewed. Twenty women of childbearing age who had had children in the last three years were interviewed to see whether those using TBA services perceived any changes in the practice of the TBAs, before and after training; and if they saw or experienced any differences in the performance of trained and untrained TBAs. Lastly, 4 groups of community opinion leaders, one group of which included leaders from 5 villages, were involved in focus group discussions. This provided the opportunity for feedback on community perception of the program and its impact, as well as ongoing and potential support.

Although this was a small sample, the consistency of the feedback from numerous sources lends validity to the findings and appendices. All tools used in the clinical component of the evaluation are included in an addendum to this report.

2.2 Impact on Services Utilization

The TBAs' provision of services to thousands of women in rural areas has increased the quantity and quality of available services in antenatal care, supervised deliveries, post-natal care, family planning, and some PHC care. In addition, TBAs trained and supported by the NTBA are now referring women and children to MOH facilities for care.

Table 2 presents the services provided by trained TBAs in the five USAID program-supported regions. Services for 1990 and 1991 are compared and percentage increases shown.

Table 2

**Quantity and Comparison of 1990 & 1991 NTBA Reported Services
in Five USAID Funded Program Regions
(Numbers in parenthesis are numbers per TBA)**

	1990	1991	Percent Increase
Number of Trained TBAs	1,364	3,040	+122%
Antenatal Attendances	5,751	21,102	+266%
Antenatal Visits	7,989	40,638	+408%
Deliveries			
Total Births	5,660	18,504	+227%
Live Births	5,580	18,303	+228%
Stillbirths	80	201	+151%
Mothers Alive	5,626	18,346	+226%
Mothers Dead	7	4	-42%
Post-Natal Attendances	3,027	13,746	+354%
Post-Natal Visits	6,263	39,586	+532%
Sales			
Condoms	8,646 (6.3)	31,664 (10.4)	+266%
Vaginal Tablets	8,706 (6.4)	30,148 (9.9)	+246%
ORS Sachets	3,923 (2.9)	13,350 (4.4)	+240%
Referrals			
ANC	1,601	7,752	+384%
Delivery	231	861	+272%
PNC	384	3,349	+772%
Total Referrals	2,216 (1.6)	12,375 (4.1)	+458%

There were 1,346 TBAs in 1990 and 3,040 in 1991. The population base (N) served was the same in both years. Training was conducted in 1990 and 1991. Data for the other five regions was not yet compiled by NTBA.

2.2.1 Antenatal Clients and Visits

NTBA reported in 1990 that some 5,751 clients received antenatal care through 7,989 visits from trained TBAs. In 1991, that number rose to 21,102 women receiving 40,638 visits. This reflects a significant quantity of women receiving care from TBAs as well as a 266 percent increase in the number of clients and more than a 400

TBA sales of FP supplies currently represent only about 4 percent of MOH sales and .6 percent of countrywide sales. The proposed introduction of the sales of oral contraceptives by trained TBAs has implications for further NTBA attention to the improvement of TBA promotion skills, reporting, analysis, and further training.

It is anticipated that the oral contraceptives will have an even higher acceptability by women than vaginal tablets and will result in considerably higher sales. This has implications for the future NTBA program in the areas of training, support, coordination with the MOH/MCH division on norms development, improvement of the HIS reporting system, etc.

2.2.5 Referrals to MOH Facilities for Antenatal Care, Delivery and Post-natal Care

By and large, TBAs did not make referrals prior to NTBA training and supervision. Table 2 shows that in 1991 trained TBAs provided a total of 12,375 referrals, including 7,752 for antenatal care, 861 for deliveries, and 3,349 for post-natal care. Together, these referrals represent an increase of 458 percent over the 1990 total of 2,216 referrals. Although TBAs conducted 18,440 supervised deliveries in 1991, only 3,349 or 18 percent were referred for post-natal care. Over this period, referrals per TBA rose from 1.6 per TBA to 4.1 per TBA.

In conclusion, in providing services to thousands of women, the NTBA Program working jointly with the MOH has made significant strides in increasing the number of women with access to antenatal and post-natal care through TBAs and referrals to MOH and private facilities. These services essentially were not provided before the NTBA training.

2.3 Impact on the Quality of Care Provided

The NTBA Program has had a positive impact on the clinical skills of the TBA, having introduced new skills and modified others. On an individual level, TBAs display varying degrees of competence in different skills, ranging from mastery in some to mere acquaintance with and lack of knowledge in others.

2.3.1 Antenatal Care

Clinical skills in antenatal care were assessed using 36 skills in the clinical skills checklist (see Section 2.1.2) in the following four areas: introduction to client, history taking, physical examination, and advice and referral. These antenatal skills are included in NTBA Manual Three and were to have been taught to the TBA during NTBA training.

The 44 TBAs tested in two regions in general performed very well. The majority (77 percent) performed satisfactorily in more than 80 percent of the antenatal skills tested.

Trained TBAs performed particularly well in pregnancy history taking, examination, and referral for normal/routine pregnancies. They performed consistently less well on history taking, examination, and referral for complications of pregnancies. This could have been because training and supervision were not as strong for identification and care of complications. Before the development of training in antenatal skills, however, a review of the role of the TBA in the care and/or referral of women with complications will need to be assessed by the NTBA and MOH. It may be decided that the training should focus on how to identify complications and make referrals, with only limited skills taught in complications.

Training in antenatal skills included only limited hands-on practice with clients. The need for future training to be done in clinics and hospitals was discussed with the NTBA. This would allow TBAs supervised learning/practice, especially for pregnancy complications. Decisions about the appropriate role of the TBA will affect the decision regarding hands-on practice.

Focus group discussion revealed that TBAs did not carry out antenatal visits, provide antenatal care or refer clients before their NTBA training. TBAs stated that since NTBA training they are no longer afraid of MOH staff.

Recommendations

NTBA training and supervision should continue to reinforce the TBAs' skills in provision of antenatal care for normal pregnancies with increased hands-on training and supervision. Additional training should be focused on improving TBA skills in history taking, physical examination, and advice/referral for women with pregnancy complications. Future training will need to be based on NTBA/MOH decisions regarding the TBAs' role in care and referral of pregnancy complications.

The NTBA and the MOH should promptly and periodically assess the advisability of increasing the number of antenatal referrals in the context of the MOH's capacity to absorb a significant increase in numbers of referrals at their outreach MCH clinics and other facilities.

2.3.2 Birth and Delivery

A KAP questionnaire used to measure skills at birth and delivery was developed and administered to 44 trained TBAs, since it was not possible to observe their clinical practice. Responses were compared to the expected outcomes of the training program as listed in volume two of the Ghana Manual for Training Traditional Birth Attendants and to those of untrained TBAs (see Section 2.1.2).

Results again showed that trained TBAs performed well under essentially normal delivery conditions. They correctly and

consistently performed hand washing and delivery hygiene, properly identified signs of true labor, responded correctly to the woman's readiness to push, and reported appropriate willingness to make referral in emergencies. Their kits contained soap and ligature in spirits and clean razor blades for hygienic delivery care and prevention of perinatal tetanus. Untrained TBAs do not generally wash their hands and do not have kits for clean, safe deliveries.

In responding to what TBAs had actually done in complicated cases or under emergency situations, however, little difference was noted in the answers given by trained and untrained TBAs. For example, both groups responded that they will first deliver a baby known to have a cord around its neck, and then cut the cord. This is inappropriate care and TBAs have been instructed differently during NTBA training. Secondly, trained TBAs were instructed to refer breech presentations without attempting to deliver. Only 60 percent of trained TBAs made referrals in such cases and this was after they had attempted to deliver the breech. This was also assessed to be an inappropriate action by the trained TBA.

This assessment appears to indicate that trained TBAs performed less well on complicated cases or emergencies, with little change in their performance since training.

Recommendations

NTBA review of the NTBA training and supervision should be carried out to strengthen further the clinical delivery care given by TBAs. Care for complications of delivery will need additional emphasis if NTBA and the MOH decide that the TBA should have a significant role in management of complicated deliveries.

The NTBA should work with the MOH to develop case studies of difficult cases (stillbirths/maternal mortality) to define needed changes in care and referral. Study of complications should be done carefully so as to maintain the program emphasis on support to the TBAs for the high percentage of normal deliveries which the TBAs perform successfully.

2.3.3 Post-Partum Care

Care of the Woman

Using the post-partum clinical skills checklist developed by the evaluator, the post-partum clinical skills of 36 TBAs were observed. TBAs as a group demonstrated mastery in the area of establishing interpersonal relationship with the clients; in the examination of the breasts; in making referrals for immunizations; and in advising on nutrition with a consistency of over 92 percent. Other skills need improvement. Only about half of the TBAs were able to perform adequately in the areas of history taking and physical examination of the fundus, perineum, checking the lochia, and checking for signs of anemia. Performance of TBAs differed by

supervisor. This has implications for future training and supervision.

Overall, the TBAs' post-natal care skills were not as strong as their antenatal or delivery skills. This implies the need to place increased emphasis on post-natal care in future training and supervision. Nurse midwives indicated that generally pre-service training in post-natal care is weak and that the nurse midwifery curriculum is being reviewed in anticipation of strengthening of the post-natal skills component. It was not possible, however, to establish the extent to which TBA performance on post-natal care is indirectly related to skills of their trainers and hence to the trainers' pre-service midwifery program.

The above has implications for the NTBA to improve the post-partum care component of the supervisory training and strengthen the initial training of new TBAs.

Care of the Infant

The same sample of trained TBAs, tested for care of the infant, performed uniformly well (100 percent) on hand washing and proper infant and cord care. All performed cord care properly and used spirits or mercurochrome as taught. A very high percentage (92 percent) counseled on proper breastfeeding and introduction of solid foods. Counseling on the length of breastfeeding and the appropriate month for introduction of solid food, however, varied. Untrained TBAs did not generally wash their hands, provide correct eye or cord care, or offer breastfeeding or nutrition counseling (see Appendix B).

Recommendation

NTBA should carry out an in-depth review of the training of the post-natal component. Strengthening hands-on training, especially in the areas of history taking and physical examination of the woman, is needed. Counseling on breastfeeding and introduction of weaning foods should also be reviewed and strengthened.

2.3.4 Family Planning

To evaluate FP skills, 33 TBAs were tested using an FP skills checklist to assess their FP skills in the areas of introduction of FP, FP methods information, reinforcement and clarification of FP use, and referral (see Section 2.1.2).

Overall the TBAs performed best in providing clear and correct information and giving a sales pitch for the items they had for sale. They were much less able to provide information on other FP methods, such as pills, IUDs etc., which were available at MOH facilities and on the private market. More than 90 percent of TBAs referred clients to the MOH for FP services. With respect to FP promotion skills, TBAs often did not know how to introduce the FP

topic and did not generally encourage women to ask questions. They also did not know how to encourage clients to continue to use a given method.

A small group of 20 women were interviewed to assess where and how they got FP advice. Half of the women identified the TBA as the first source of FP information and almost three-quarters stated that their TBA had discussed FP with them. Only one of these women, however, had used or was currently using an FP method. The community leaders recommended that TBA be trained further in FP skills. The NTBA plans a stronger role for the TBA in FP and is preparing her to sell oral contraceptives. This has implications for strengthening NTBA training and supervision in FP promotion, broader FP methods information, and client information and counseling.

Recommendation

A strong family planning component should be developed for the training and support of TBAs. Special emphasis should be placed on the strengthening the motivation of TBAs for FP promotion and additional skills in FP promotion. Additional training and support in FP methods information should be incorporated into training and support to TBAs, especially if oral contraceptives and other FP methods are added to TBA sales. Cooperation of the NTBA with MOH/MCH and other FP institutions is needed.

2.3.5 Referrals

Although referrals for post-natal care are usually for a check-up of the baby and an examination of the mother, it is possible that some referrals (especially the second referral, at six weeks) may include FP information to the client. This has implications for increasing the woman's exposure to FP information during post-natal referrals.

In addition, as the number of post-natal referrals increases, the capability of the MOH facilities to absorb additional clients may become an issue. At the same time, additional post-natal visits also imply an opportunity to offer family planning information and services to clients. The NTBA and MOH can also work to improve the quality of services offered.

Recommendation

NTBA and MOH should continue to encourage TBAs to refer women, especially those at risk, for services. The MOH system for return referral to TBAs should be strengthened to assure continuity of care of the women and recognition of the TBAs. NTBA and MOH analysis of TBA reporting form returns should be strengthened to assure that the high number of at-risk mothers receive appropriate care.

The NTBA and the MOH should carry out periodic reviews of referral criteria to assure the continued capability of the MOH to receive and care for high-risk women.

2.3.6 PHC Skills

To assess TBA capability to expand into other PHC activities, 60 TBAs were questioned about their knowledge of how to prepare a salt/sugar solution. Only one-third were able to describe it accurately. Further study is needed since training focused on ORS packet preparation. It is difficult to establish the implications for future training for adding unfamiliar PHC skills to the responsibilities of the TBAs.

Recommendation

The NTBA should monitor TBA sales of FP supplies and ORS with analysis of the monthly TBA returns. Additional training, support and supply systems development will be needed if the TBAs expand their sales to include oral contraceptives.

2.3.7 TBA Care and Referral of At-Risk Women

Nationally, TBAs reportedly perform some 70 percent of the deliveries, primarily in rural areas. A high percentage of these women are high risk as currently defined by the MOH MCH division, i.e., primiparas and para-five and above (first birth, fifth birth and above). NTBA training using MOH norms instructs trained TBAs to refer all primiparas as well as all women para-five and above, (NTBA manual volume I, page 12).

Table 3 shows that 43.5 percent of the total women delivered in a sample of 239 women would be considered high risk according to the MOH definition (in the sample, 39 or 6.6 percent were primiparas, 70 or 11.8 percent were para-five, and 130 or 21.8 percent of the total were para-five or above). The evaluator's sample data appear to indicate that TBAs are not referring all high-risk women for delivery. This may have indications for the retraining in the norms to TBAs, both in supervisory visits and during retraining.

There may, however, be a number of reasons why these high-risk women are continuing to be delivered by TBAs. Some of the trained TBAs stated that the women sometimes delay notifying the TBA until the process of delivery is far advanced, causing her to deliver the women instead of referring her. It is also possible that the TBA had even referred the woman. Another reason may be that multiparas who have always been delivered by their TBA may wish to continue while primiparas may be more easily referred. More study is needed on this issue.

Recommendation

The NTBA and MOH/MCH should investigate the reasons why TBAs continue to deliver high-risk women and consider additional motivation/training of TBAs on how to refer high-risk women. Emergencies, however, must always be taken into account. Since a relatively high percentage of women are apparently high risk, and increased referrals may strain the MOH MCH capacity to provide care, monitoring by NTBA of increased numbers of referrals and joint NTBA/MOH review of norms will need to take place.

Table 3

Referrals of Women at Risk in Five Project Areas
March 1, 1991 - February 1, 1992

Area	Total Deliveries	First Births		5 Births		5+ Births		Total At-Risk Delivery		Receiving Tetanal	
		N	%	N	%	N	%	N	%	N	%
Yawsea	55	2	3.6	6	11.0	11	20.0	19	34.5	49	89
Tanoso	77	2	2.6	14	18.0	13	16.0	29	37.7	69	90
Techiman	81	8	0.9	12	14.8	8	9.8	28	34.6	81	100
Badu	144	20	13.8	15	10.4	39	27	74	51.4	99	69
Gamoa Aguan	54	3	5.5	01	1.8	14	25.9	18	33.3	43	79.6
Saltpond	120	2	1.7	11	9.2	35	29.2	48	40.0	93	77.5
Winneba	63	2	3.2	11	17.5	10	15.9	23	36.5	54	85.7
Total No.	594	39		70		130		239		488	
Percent Total	100		6.6		11.8		21.8		43.5		82.2

Source: TBA Record Books

2.3.8 Tetanal Immunizations

In the sample used to identify high-risk women, 82 percent of the women had received tetanal immunizations (see Table 3 above). This figure compares favorably to a reported national MOH coverage of 42 percent in 1991.

2.4 Impact of NTBA Program on Perceptions of TBAs

2.4.1 TBA Self-Perceptions (Morale and Performance)

Overall the training and support of the program has boosted the confidence and self-esteem of the TBA. In the focus group

discussions, TBAs stated that involvement in the program has increased their status with the Revolutionary Organs, Chiefs, and other community leaders and decision makers. It has linked them with the MOH and reduced their fear when conducting deliveries and making referrals. They thus feel freer to refer, do so earlier, and even accompany the clients to health care facilities.

Some TBAs report increased income and community support to ensure that they are paid (see Appendix B). Program impact on TBA income warrants further study.

Untrained TBAs may be emulating trained TBAs in some instances, adopting skills that were introduced as part of the training program. Ten percent of the untrained TBAs, for example, claimed that they were delivering women on their backs; 70 percent said that they were using a new razor blade to cut the cord (see Appendix B).

2.4.2 Community and Client Perception of TBAs

Four focus group discussions of opinion leaders were conducted. Opinion leaders were unanimously positive about the services provided by TBAs. They expressed the opinion that the TBAs should provide, and are currently providing, services in antenatal, delivery, and post-natal care. All groups interviewed agreed that the TBAs should be active in FP. Most, however, did not feel that the TBAs were fully prepared for this task. They stated that they felt the TBA could and should provide this service if properly taught. Opinion leaders also stated that wished to see the TBA role expanded to include additional PHC services.

In general, opinion leaders reported changes they had observed in the health of community women, i.e., improved deliveries, fewer tetanus cases, improved nutrition, and more referrals and better interaction with MOH hospitals and clinics.

Opinion leaders all reported active community involvement in TBA selection and support for training expenses. This involvement has promoted a strong sense of community ownership of the program.

Communities have demonstrated willingness to support the TBA, having helped with construction of buildings/rooms for deliveries and with the TBA's farm chores. In some instances, communities have established TBA fees and helped ensure payment for her services and replenishment of her supplies. One community has even levied a fine against any woman who goes to an untrained TBA. Opinion leaders have discussed the need for a second TBA in each community for continuity of service (see appendix B for additional information on community perceptions of TBAs).

Perceptions of two groups of TBA clients were elicited during focus group discussions. The TBA continues to be the choice for care of all participating clients. They perceive improvements in the TBAs'

performance, especially in improved hygiene and examinations during pregnancy and labor. The trained TBA also provides care for the mother and baby for a week following delivery. None of these services were provided by these TBAs before NTBA training (see appendix B for additional information).

Sustainability of the TBA program will depend heavily on community support of the current TBAs' training and performance and will be key to future expansion of the TBA program and its long-term viability.

Recommendation

NTBA and MOH interaction with communities and clients to identify and address their perceptions and needs should continue to receive high priority. Interaction can take place through increased pre-training community assessments, MOH/community meetings, etc. The need for community support should be stressed during supervisory visits.

2.5 Unmet Needs (Other Clinical Issues)

The National Nutrition Survey (NNS), the MOH 1986 report on hemoglobin (HB) levels of women, found that, by region, 47.6 to 68 percent of women had hemoglobin levels from 6-10 grams while another 8.6 to 34.8 percent had levels of 6 or below. Women in the Northern region and Upper Eastern and West regions are the most severely affected. A small spot check of iron levels done as part of this evaluation found that only 2 out of 11 women in one clinic had levels of 10 or above. Another site showed that 6 out of 19 had HB levels below 10 grams. A third spot check showed that 7 out of 10 had HB levels below 10.

Anemia seriously affects the health of pregnant women. MOH norms state that pregnant women should receive iron. Iron is reported to be given in small amounts to provide one tablet for each day between women's scheduled visits to MCH clinic. Since many women delivered by TBAs only visit the MCH clinic once or twice, the number of iron tablets sold to them by the MOH is judged too small to improve their iron status.

Recommendation

TBAs should be able to sell iron tablets to their clients in large amounts to increase iron levels during pregnancy. Since virtually no side effects from high iron intake is known, the benefit of trained TBAs' selling iron is clear. This addition has implications for the NTBA training, supply and HIS systems and will need to be incorporated into both the supervisory training of TBAs already trained and into the training of new TBAs in the future NTBA Program.

3. Training Systems Review and Assessment

3.1 Overview

3.1.1 Evaluation Methodology

The training process, materials and methodology used in the NTBA Program were reviewed, using extensive document review, job analysis, discussions with NTBA, MOH regional and district staff, structured interviews, and observation of simulated performance of NTBA MOH trainers, master trainers, and TBAs.

Interviews were held with 22 master trainers and TBA trainers, the four NTBA facilitators, and six TBAs. No NTBA program training was observed as none was scheduled during the evaluation. Instead, NTBA facilitators, master trainers, TBA trainers, and TBAs simulated how they would teach specific skills, e.g., how they would explain to mothers how to make and use ORS to mothers, how they would share FP health messages, etc.

A detailed review was made of the NTBA program training materials to assess the teaching/learning methodology and content for appropriateness and completeness as specified in the SOW. (The materials reviewed are listed in Appendix A.) The NTBA team requested that the materials be assessed from a competency-based teaching/learning perspective.

3.1.2 Accomplishments

The NTBA training program has successfully achieved a number of its stated objectives. The NTBA has developed a uniform support system that provides initial training and follow up supervision for some 3,171 TBAs, 307 MOH trainers, and 63 Master Trainers (see Table 1).

Thousands of community leaders and hundreds of MOH regional and district health team members, especially at the community level (B) have been oriented to the program and its goals of service. Program guidelines and training manuals have been developed and used for training and supervision. A TBA inventory has been established and is revised annually.

The success of the NTBA program to date can be attributed to fundamental lessons, not only learned by the TBA but applied. Since people learn best when they have a perceived need and see the benefits to their jobs of what they have learned, the TBAs, during the NTBA training, have learned the skills they perceived as most important.

Traditionally, the TBA's role has been primarily to assist with labor and delivery, and in this area, the NTBA training improved TBA skills. On the other hand, skills in antenatal, post-natal and family planning have not improved as markedly. This could have

been related, at least partially, to the importance that the TBA perceived (at the time of NTBA training) to learning these skills. If this is the case, TBA awareness may need to be raised concerning the importance of other than delivery skills.

TBAs have mastered some key skills, e.g., referring antenatal clients for examinations and tetanal, hand washing before delivery, improved delivery practices and clean cord care. Other skills such as early identification and referral of at-risk mothers, and post-natal, PHC and FP skills, have not been consistently mastered. These findings are consistent with the findings in the clinical assessment on their performance.

Their lack of mastery can be related to at least two factors: 1) the TBAs do not perceive these as priority learning needs (this will require further study) and 2) the process of training did not provide adequate skills development. If the TBAs' own perception of need is key to their learning, this has important implications for the NTBA raising TBA awareness during future training efforts.

In general, NTBA/MOH follow-up of TBA skill practice on-the-job by supervisors was not structured. In addition, weaknesses in the NTBA management systems affected TBA support and program feedback to improve training.

In conclusion, although there are 3,173 trained TBAs and their trainers, in some technical areas, TBAs have not been adequately trained to provide all the services anticipated in the original program design.

3.2 Development of NTBA and MOH Core Training Capability

With the rapid expansion of the NTBA Program during the first phase, the objective of training large numbers of TBAs was given priority over the development of a core NTBA/MOH training capability. The capability of NTBA training coordinators, MOH master trainers, and MOH trainers at regional levels has not been developed in the key skills required to plan, develop, and implement training and support for the TBA and the NTBA program. The current level of capabilities can serve as a base for the future program's development to conduct training and strengthen supervision.

Recommendation

A core capability should be established and developed for NTBA coordinators and MOH master trainers and training of trainers (TOT) as the basis for development of future NTBA training. The NTBA should place emphasis on intensive technical assistance (TA) and short-term courses to develop NTBA and MOH core training capability to master skills in training and program planning, management, monitoring and evaluation.

Strengthening Supervision

The goal of the NTBA program is to improve antenatal delivery and post-natal and FP services by training and supervising TBAs. At this point, the most practical training intervention for the future program would be to strengthen the supervisory component for the already trained TBAs before new TBAs are trained. Strengthening the supervisory component would improve the skills of TBA trainers and supervisors. This should bring more structure to the supervisory process, raise awareness as to the importance of these skills to be mastered, and help those TBAs already trained to master required skills as they practice using them on-the-job.

Recommendation

As a first step, strengthen TBA trainers/supervisors' teaching, management, and supervision skills to the level of mastery through in-service training. Design and conduct in-service training of existing TBA trainers/supervisors, pairing them with new untrained TBA trainers/supervisors. This approach to team teaching should help the trained TBA trainers/supervisors increase their skill mastery as well as their basic competency.

This intervention can be linked to the training of the new tranche of 3,000 TBAs. Some trained TBAs have already started sharing their new skills with untrained other TBAs. The majority of the TBAs interviewed are interested in training their sister TBAs.

3.3 Training Development Process Assessment

The NTBA did not follow a disciplined, formalized approach for developing the training process to be used for master trainers, TBA trainers and TBAs. None of these groups had adequately learned or internalized the training development process concepts, techniques, and skills that would allow them to develop and manage these in future training programs. The TA appeared to have focused on a strong, active role in training activities by TA advisors, with less emphasis on strengthening NTBA staff skills.

Figure 1 (see next page) presents this NTBA training development process.

Recommendation

The NTBA should develop, document and follow a systematic process for training development, using the competency-based learning model described in this section at the programmatic level. Technical assistance to the NTBA should assure that the emphasis is on the development of the NTBA/MOH capability for future institutionalization. TA will need to be consistent in its guidance to NTBA if this process is to be operationalized.

Figure 1

Training Development Process

1. Assess community health needs
2. Analyze jobs
3. Assess learning needs and plan training
4. Establish management support systems
5. Develop learning materials
6. Implement training
7. Monitor and evaluate program

3.3.1 Assessment of Community Health Needs

Assessing community health needs is essential, but there was no documentation of any NTBA formal process for building NTBA training and support on the basis of assessments of the communities' TBA related needs. The NTBA had confused the community health needs assessments with the KAP of TBAs conducted by trainers or the TBA Practices, Beliefs and Customs study. These two studies are learning needs assessments but do not identify community health needs in the areas of prenatal, delivery, post-natal and family planning services.

OR studies in Dangbe and other studies were also done, but NTBA and MOH master trainers who actually planned the training did not enter the communities to be served and interview women and other community members about their perceived health needs as the basis for developing the NTBA curriculum. OR cannot replace the need for a community assessment on which to base training.

Recommendation

Assess community health needs in ANC, delivery, PNC and FP as the basis for planning any future NTBA training. Provide TA to NTBA to develop a process for community assessment. This includes the individual community assessments, analysis of jobs, prioritizing community needs for use as indicators, and training TBAs in the methodology.

3.3.2 Job Analysis

A TBA job analysis (or task analysis) is the process of breaking down the responsibilities of the TBA's job to determine in specific terms what s/he must do in her/his role to deliver essential health services. A job analysis is much more specific than a job description, but the NTBA appeared to have used a general job description as the basis on which to develop training. No job

analysis for master trainers, trainers etc., had been developed and documented for review.

Numerous studies and reports were reviewed: NTBA reported that these studies were used in a generic way to determine learning needs, primarily of TBAs. Focus groups were also held. Entry level knowledge (but not performance) assessments were done during TOT. What had previously been done to assess learning needs has been well documented but does not replace the need for a job analysis for each category of worker to define training needed.

Discussions with NTBA trainers allowed them to realize that a job analysis is key to assessing learning needs and developing training for their future program. NTBA will need to be clear about the job tasks, competencies and skills (as well as knowledge and attitudes) needed by TBAs and their trainers and supervisors.

To determine if the training development process, materials and methodology were appropriate, the jobs of master trainers, trainers, NTBA staff, and others were analyzed in depth in the course of the evaluation (see Appendix C, NTBA Job Analysis). The job analysis was done by reviewing the training materials, other program documents, and by interviewing the NTBA team, regional contact persons, master trainers, trainers, and TBAs. Seven tasks were identified, broken down into 41 competencies and 262 skills.

Recommendations

Use a disciplined approach to developing the job analysis as a basis for planning NTBA training. The job analysis developed by the evaluators (see Appendix C) could serve as a resource on which to base analysis and documentation of jobs of NTBA workers and TBAs to be trained.

Provide TA to NTBA to further analyze the jobs of master trainers, trainers, TBAs, and others in collaboration with the Division of Manpower and Training and other appropriate MOH Divisions.

3.3.3 Assessment of Learning Needs and Plan Training

The assessment of learning needs would be more accurate if the job competencies and skills were used as the basis for the assessment. There should be a performance component to assessing (pretesting) learning needs against established performance criteria stated in the form of a skills checklist (see Appendix C, "Writing Learning Objectives").

Master trainers and TBA trainers/supervisors were asked to demonstrate how they would train a TBA on the topics of using ORS and salt sugar solution (SSS) and of providing family planning messages. A more extensive assessment of TBA performance and analysis of learning needs was done by the clinical specialist evaluating the impact of the program.

Recommendation

Assess learning needs against job requirements using the skills checklist to identify in-service training priorities for TBA trainers/supervisors. Provide TA to NTBA to conduct a learning needs assessment of TBA trainers/supervisors (see Appendix C, Job Analysis, Task I, Competency 4).

3.3.4 Establishment of Management Support Systems

Since the overall emphasis of the NTBA Program was on training, management systems development lagged behind. NTBA staff, MOH master trainers, and trainers were given general training in reporting, referral, data analysis, supervision, and other management responsibilities. It will be difficult to develop strong training in NTBA management systems, however, until the NTBA management systems are themselves strengthened. NTBA, MOH master trainers and trainer responsibilities should flow from a rigorous development of management systems and a revision of tasks before further training. The Operations Research Final Report June 1990 had recommended the strengthening of management systems.

(The job requirements for managing the training aspects of the program are documented in Task II: Analyze, Plan and Provide Management Support, Addendum, Job Analysis, and can be used for broader training program development.)

Recommendation

Strengthen training in the management support systems. Simultaneously, NTBA will need to develop the management systems. Training, especially of the core NTBA team to develop and manage the NTBA management systems, will need to be strengthened with strong TA and short courses. The management component of training for the master trainers, TBA trainers/supervisors and members of the RHMT and DHMT will need to be revised and strengthened to prepare them to manage the NTBA Program systems described in the management section.

3.3.5 Development of Training Materials

Major training materials developed under the program include the following:

- National Traditional Birth Attendants Program Guidelines, revised June 1989
- Trainers' Manual for the Training of TBAs in Ghana, February 1990
- A Manual for the Training of TBAs in Ghana, Volumes I-III, September 1988.

The overall design was done adequately and presented clearly but the general content presentation is confusing, as technical content

is mixed with training sessions containing notes to the trainer. The language level of the technical content of the manuals is excellent and content is sound. There is no clear presentation of health messages to be communicated to TBAs, however, a major omission. Other important skills such as how to properly remove and cut the cord from the baby's neck were also not included in the content. The learning objectives in the NTBA manuals were not presented as specific, observable or measurable. Learning objectives are essential if the learner evaluations are to be valid and reliable.

The TBA Manuals are appropriate for adult learners. Songs are very popular with the TBAs. The questioning technique used in the TBA Manuals is very good. There is an extensive use of role play, perhaps inappropriately when actual practice could have been done.

The NTBA were not the prime authors of the training materials. Rather, the materials had been developed/adapted by consultants, with NTBA staff review during the process. NTBA did not document the existence of the process for teaching/learning materials development.

Distribution of the TOT Manual and TBA Training Manuals, Vol. I-III to master trainers and trainers was adequate but medical assistants and other members of the DHMT and the RHMT did not receive copies. Wider distribution of these materials could help to orient other team members to the NTBA program. A short orientation document, which is similar to the NTBA Program Guides and which defines their responsibilities toward the NTBA program, should be developed.

To supplement NTBA manuals, the NTBA also needs additional training and management resource materials. The existing TOT manual is generally adequate for most areas but additional resource materials, especially for management strengthening, are needed.

Recommendation

The NTBA and MOH should analyze, strengthen and document the process for teaching/learning materials development. This should include development of a materials development plan using a competency-based methodology, the establishment of clear learning objectives, and strengthening training materials design and content (including clarifying health messages). Adequate distribution of manuals should be assured. NTBA will need to define a process for periodic evaluation of materials development (see Appendix C, Job Analysis, for detailed examples to assist the NTBA in developing materials).

The future program should identify additional quality resource materials to supplement NTBA manuals.

The NTBA budget should include additional funds for adequate manual distribution, e.g., for the NTBA Program Guidelines and the TOT

Manual, to allow distribution to RHMT members. Funds for management systems materials for use by trainer/supervisors should also be included.

3.3.6 Implementation of Training

The NTBA appears to have no model of the teaching/learning process followed in the program. What has already been done in training and what is desired in the future is compatible with The Competency-Based Learning Model (CBLM - see Appendix C). NTBA staff stated their interest in incorporating CBLM into their training at all levels.

Recommendation

Establish and follow a competency-based learning model at all levels of training. A primary consideration should be how best to institutionalize core competence and the training of trainers and TBAs within the MOH (see Appendix C on the steps in the CBLM). NTBA will need particularly to strengthen the area of practice for mastery.

3.3.7 Monitoring and Evaluation of Program

Training indicators can be used as sentinel markers for NTBA to evaluate their training. Although information from OR was used to plan training, the NTBA has not evaluated its training programs internally. General goals and objectives were stated by the NTBA Program, but performance indicators for monitoring progress were not developed as part of the training development process and information was not routinely generated using indicators for decision making by the NTBA and MOH.

In evaluating the learners' performances, NTBA conducted "knowledge" pre-and post testing in workshops and TOT training. Discussions elicited that "training was too short and all appreciated their training." This type of feedback is too general to serve for evaluation and redesign of training.

Recommendation

A systematic process for developing and using indicators for monitoring and evaluating program progress should be implemented and documented. NTBA and MOH staff should be trained to make programmatic decisions based on the information generated (see Appendix C, Job Analysis, under Competency 9, Skill 9.1).

4. Management Review and Analyses

4.1 Overview

4.1.1 Methodology

A systematic review was conducted of NTBA management systems. Using indicators as sentinels to measure system completeness and effectiveness, the evaluators conducted in-depth interviews with MOH officials, the Director and staff at the NTBA office, master trainers, trainers, RHMTs, DHMTs and others. In a number of cases, graphic representations of a number of systems were developed to clarify the systems and their functioning. These were reviewed with MOH and NTBA staff to assure the accuracy of the information being collected.

4.1.2 NTBA Program Management Systems Needs

Establishment of the NTBA program implies the development of management systems to plan, develop, manage, implement, monitor and evaluate its activities effectively. These include the following: personnel, health information systems (HIS), drug and medical supplies, communications, referral, facilities, etc. Because the emphasis has been in initiating training in the regions during the past three years, the development of management systems to support the NTBA Program has not received equal emphasis. During the future program, the need will be to consolidate the nationwide TBA program with considerable effort to develop and strengthen the management systems which will promote sustainable support for long-term training and supervision of TBAs.

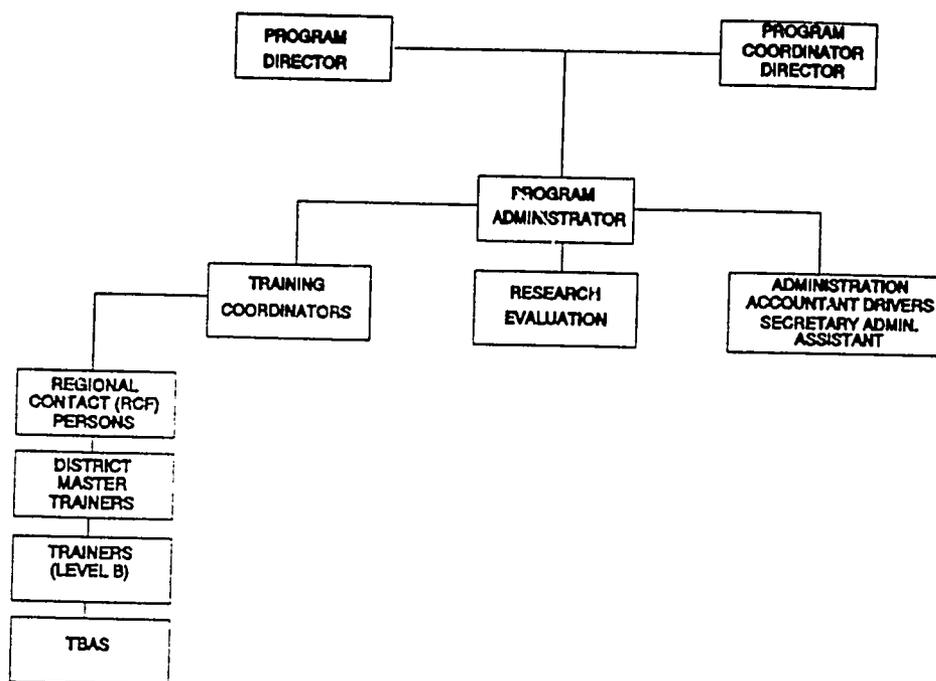
4.2 Organizational Structure and Personnel

Currently, the NTBA program's staff includes a Director (at 30 percent time), a program administrator, three training coordinators, and several administrative staff and a research and evaluation unit (see Figure 2 on the following page).

Figure 2 shows, the NTBA exercises direct line authority over MCH staff at the regional and district levels. It does not, however, show the relationship to the MOH at the central level. The NTBA Director relates directly to the Director of Health, MOH, while the NTBA staff coordinate with the MCH, Training, and Empower Divisions. Neither relationship is shown on the current organizational chart.

The NTBA uses a direct line/authority relationship to MOH contact persons, master trainers and trainers at regional and district levels. The advantage of this process is that it has allowed the NTBA Program to initiate training of trainers and TBAs rapidly, do

Figure 2
Current National TBA Program



direct data collection, and achieve short-term results in training thousands of TBAs and MOH staff to support them. This structure reflects the MOH practice of creating secretariats to give special emphasis to a need. The result, however, is that the NTBA tends to bypass the Regional and District directors, reportedly causing disruption of official MOH lines of authority. Likewise, this structure does not encourage the DHMTs and the RHMTs to feel the NTBA Program is theirs or encourage them to incorporate it into their overall team activities. This NTBA organizational structure will need to be adapted to institutionalize the future NTBA Program.

The research and evaluation (R&E) unit depicted in the original NTBA structure was not part of the NTBA Program. OR inputs, valuable to the NTBA planning process, were implemented through the USAID-funded Columbia University OR project prior to this project's initiation.

The Director, working only part-time on the program, is overtaxed to directly oversee staff and program activities. The hiring of

the administrator in mid-1991 allowed establishment of systems in retrospect. Training coordinators developed training but did not assume responsibilities for support systems. Job descriptions for program staff were not comprehensive enough to define responsibilities for planning, management, and monitoring of the program. Time limitations did not allow an assessment of the administrative department.

The Program Unit staff have identified needs for training and technical assistance in the areas of managerial skills, training skills, information, education and communication (IEC), accounting, administration, and computer use (see Appendix C for a more in-depth training assessment of their management skills and Section 4.10 for recommendations on a restructuring of the NTBA program).

4.3 NTBA Program Within the Context of Other MOH Reorganization Activities

The ongoing reorganization of the central MOH could not be fully analyzed with respect to its impact on the future NTBA program. Several areas, however, have been judged to be significant for their future impact:

Regionalization

The decentralization of authority and budgets to the regions will require the NTBA to work more directly with the RHMTs and will give them increased ownership of the design of future TBA training and support. As the MCH division assumes a more advisory and monitoring support role to the regions, NTBA's role will follow this mode.

Manpower and Training

The Manpower Division will also become more advisory and may help coordinate NTBA training activities. It may, for example, include NTBA program awareness in pre- and in-service training of MOH nurses and midwives.

Health Information Systems

This function will receive more emphasis in the MOH in the future and NTBA HIS will need to be coordinated with overall MOH MIS systems.

Recommendation

ACNM and NTBA should define the links with MOH units responsible for the systems with which the NTBA management systems interface. Formal initial meetings are needed as well as periodic reviews of the progress of NTBA systems development and their linkages with MOH related systems.

4.4 Health Information Systems

The NTBA initiated data collection using several forms, including the individual TBA recording book, the monthly individual TBA and summary TBA (for 10 TBAs), the district monthly summary, and the regional monthly summary reports. The format was developed during the previous TBA OR project: the guide that would provide standard definitions of each data item (to assure correctness and consistency) was not written or used by NTBA in its data collection and analysis. It is recognized that the HIS system should be simple, consistent and usable.

The NTBA monthly reports include the following: registration of deliveries and visits to TBAs and referrals from TBAs for antenatal care, number of deliveries, and sales of ORS and FP supplies. It does not note FP referrals. Forms are filled in by trainers from TBA records.

The HIS systems emphasis by NTBA, to date, has been on the collection of data, with little analyses or use for decision making for program management. Trainers/supervisors at level B and at district and regional levels consistently stated that they did not analyze the data or use it for decision making. This is shown in Figure 3 on the following page, which depicts the flow of NTBA data collected from individual TBAs to NTBA central office. The figure shows the appropriate steps for data analysis by MOH trainers, master trainers and RHMTs and indicates that these steps were generally not carried out. The figure also shows opportunities for feedback and potential, additional opportunities for future data analyses, and use of data for program decision making. All those interviewed expressed interest in using the NTBA data on the TBA return and summaries in the future.

The process for data analysis and feedback of data at each MOH level has not yet been formalized. A number of regions reported low level of returns collected. This sometimes resulted in the NTBA's collecting data directly from all levels of the MOH, for transmittal to ACNM and or USAID.

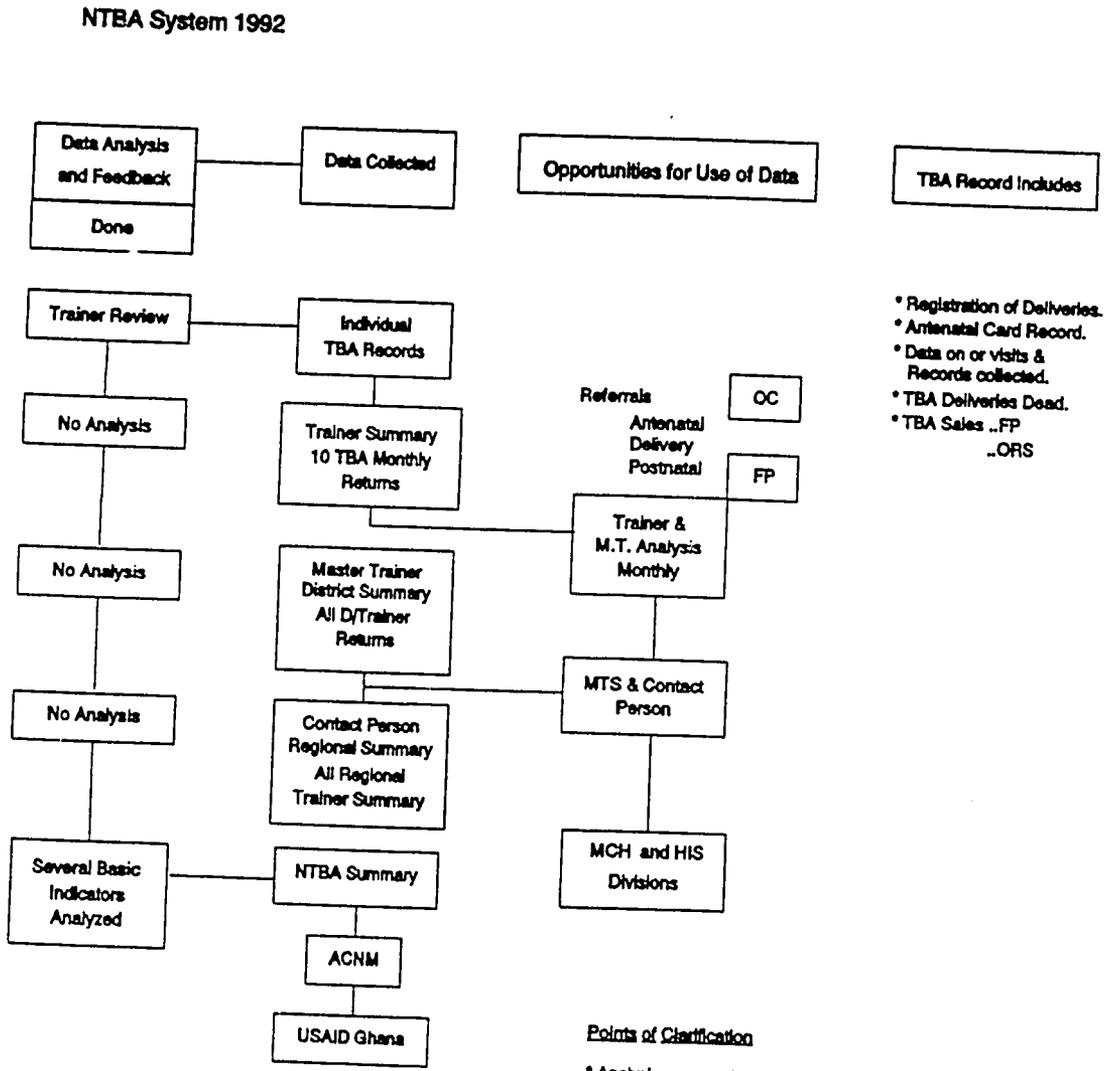
Although the MOH/MCH MIS system captures some of the TBA data on several clinic forms, TBA referral information is not included. The MCH division is testing a new HIS format. Now is an appropriate time to integrate TBA information into the MCH MIS system.

Recommendation

Analysis of data on NTBA returns and their use for decision making at all MOH levels is crucial for the future program. As part of this evaluation, the NTBA has initiated a documentation of definitions of data items to ensure standardization. ACNM, NTBA

Figure 3

NTBA Health Information System



and MOH should discuss and formalize the process for data analyses and use outlined in Figure 3, and it should be given high priority. NTBA formats (TBA return format and others) should be jointly reviewed and uniform definitions developed and standardized for data items. A limited number of additional items such as referrals for FP, and a space for analysis and actions to be taken, should be considered for addition after careful joint review.

Most important, a process for analysis and decision making at each data collection level should be established, with responsibilities of RHMTs and DHMTs for data analysis clarified. The overall responsibility of NTBA to monitor the HIS system performance and provide program-wide final analysis and feedback should be strengthened by upgrading of the HIS and data analyses skills of NTBA program staff.

Collaboration with MOH/MIS to incorporate TBA data items within the MOH/MCH MIS system being developed is also needed. This will increase the potential for MCH monitoring of TBA activities and the potential for integrated and sustained support of TBA activities within the MOH.

ACNM technical assistance in the development of this systems is needed to supplement the training of NTBA staff in HIS.

4.5 Drugs and Medical Supplies Systems

The NTBA was responsible for defining the content and facilitating the initial purchase of TBA kit contents (see Appendix B). TBAs receive their initial supplies during training. Thereafter, the NTBA should monitor the TBA sales of ORS. The TBA supply system flows through the MCH nursing personnel with little integration or participation of pharmaceutical or other RHMT or DHMT members. This procedure arose as a result of delays or a lack of FP supplies at regional or district levels. Previous MCH nurse training in FP supplies management funded through another project led to the decision of the NTBA to assign responsibility of NTBA resupply to TBAs. The NTBA system for monitoring FP sales has not been developed. Although sales data is collected from monthly TBA returns, a system to analyze this data has not been developed.

Recommendation

NTBA should develop a system to monitor TBA ORS and FP supplies. Sales data generated through the monthly TBA returns should be analyzed at each level described in the HIS system for trends in supply use by TBAs and needs for changes in inventories and additional training. Additionally, NTBA should coordinate with MOH/MCH to strengthen the design of the supply system and monitor its performance. NTBA should work with MCH to identify early deficits and trends in use of supplies. This would help with early

identification of barriers and avoid breaks in the supply of FP supplies to TBAs.

4.6 Referral Systems

Trained TBAs refer women and children to MOH level B and hospitals for routine care, complications, and emergency care, as shown in Figure 4. The NTBA referral criteria in which they are trained is outlined in NTBA manual two. They use this appropriately. The NTBA should HIS system has reported 12,375 referrals for MCH services made to MOH facilities in 1991 (see Section 2.2.5). No data on FP referrals is collected by NTBA.

There are some return referrals (MOH to TBAs) from level B staff to TBAs. Most are from nurses who trained TBAs; few are from MOH staff at hospitals.

The procedure for MOH/NTBA receipt and treatment of TBA referrals to MOH has not been formalized to assure that TBA referrals, especially to MOH hospitals, are handled effectively. This has resulted in some confusion, delays, and in some cases severe consequences for patients referred by TBAs.

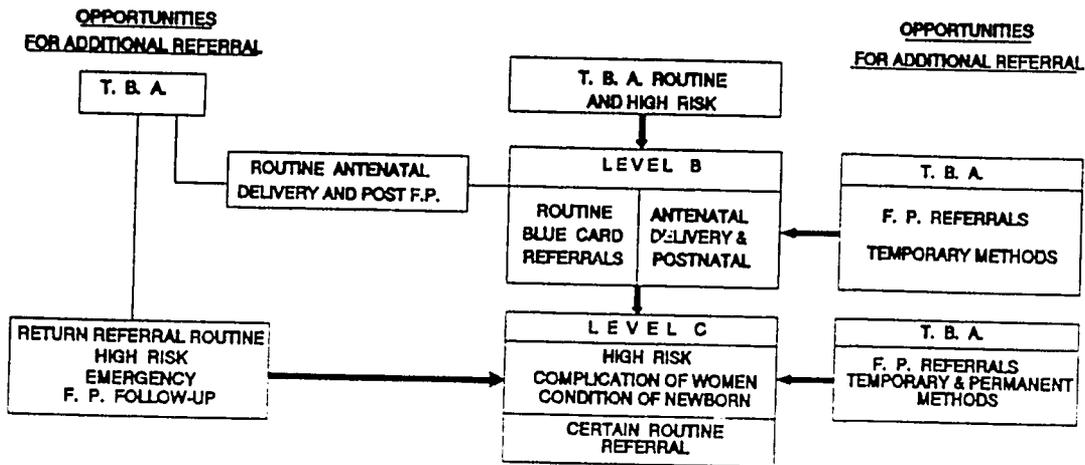
Recommendation

The MOH/NTBA should define and formalize the referral system and then incorporate it within the MOH system. Data of trends in TBA referrals should be jointly analyzed and FP referrals included in data to assure MOH capacity to receive, provide services, and "return refer" TBA patients. The MOH should periodically review data and expand services. NTBA should strengthen and integrate the referral system and monitor performance. NTBA and the MOH should use information generated on the receipt, analyses, reporting, and feedback during referrals in RHMTs and DHMTs for decision making.

The MOH/NTBA should conduct periodic joint reviews of the clinical criteria for referral at several levels. These should be presented as case studies and reviewed at RHMT, DHMT and other meetings.

Figure 4

NTBA Referral System



POINTS OF CLARIFICATION

- REFERRAL CRITERIA FOR LEVEL C DEFINED & T.B.A. TRAINED (MANUAL VOLUME 3)
- LOCAL TRANSPORT ROUTES MAY AFFECT CHOICE OF REFERRAL SITE
- REFERRAL USUALLY FROM T. B. A. TO HEALTH FACILITY, LITTLE RETURN REFERRAL
- RECEIPT AT LEVEL B WHERE T.B.A. KNOWN EFFECTIVE
- NO GENERALIZED INTERNAL PROCEDURE FOR RECEIPT OF REFERRAL TO LARGE LEVEL HOSPITALS AND RETURN REFERRAL TO T.B.A.
- RETURN REFERRAL NOT INCLUDED IN TRAINING
- F. P. REFERRAL NOT INCLUDED IN PROCEDURE, GUIDELINE ON TRAINING
- NO DESIGNATED REFERRAL DATA ITEM DELIVERY RECORD, MAY BE INCLUDED UNDER "REMARK" INCLUDED IN ANTENATAL CARE RECORD, NO T.B.A. POSTNATAL RECORD KEPT.

4.7 Equipment and Supplies System

Basic equipment, including office furniture, a laptop computer, two vehicles and paper supplies, was designated for the central NTBA office and funded by the program at start-up. Purchases were inventoried when the Project Administrator joined NTBA in mid-1991. NTBA staff have not used the laptop. It was said to be out of order and no staff were computer trained as part of the program. NTBA vehicles are subjected to routine maintenance. High mileage is noted.

Recommendation

Future program budgets should be developed to assure adequate office space and equipment for effective functioning of NTBA staff. Program staff should have continuous access to at least one functional computer to manage and monitor the various NTBA management systems, analyze data, generate documents, and facilitate correspondence. Security for equipment and staff

training in its use should be provided. The project should fund consistent access to a printer, xerox, and other basic operational NTBA necessities or be leased from nearby project facilities as long as consistent access to NTBA program activities is assured. It was not possible to assess needs for additional vehicles.

4.8 Communications System

Officially, NTBA communications flow from the NTBA Program Director through official MOH channels (see Figure 5). Other, training-related communications usually follow MCH/nursing channels within the MOH, at times by-passing the full RHMT or with copies to the Regional Medical Officer (RMO). This has affected the involvement and awareness of the NTBA Program by RHMT members. The channels of communication often then passes to the District Principal Nursing Officer (PNO), at times bypassing the full DHMT or with a copy to the District Medical Officer (DMO). Broader official support for TBAs and the program was found in the areas in which communications were passed through the RMOs and communicated to the RHMT at monthly meetings and to DMOs and DHMTs.

Recommendation

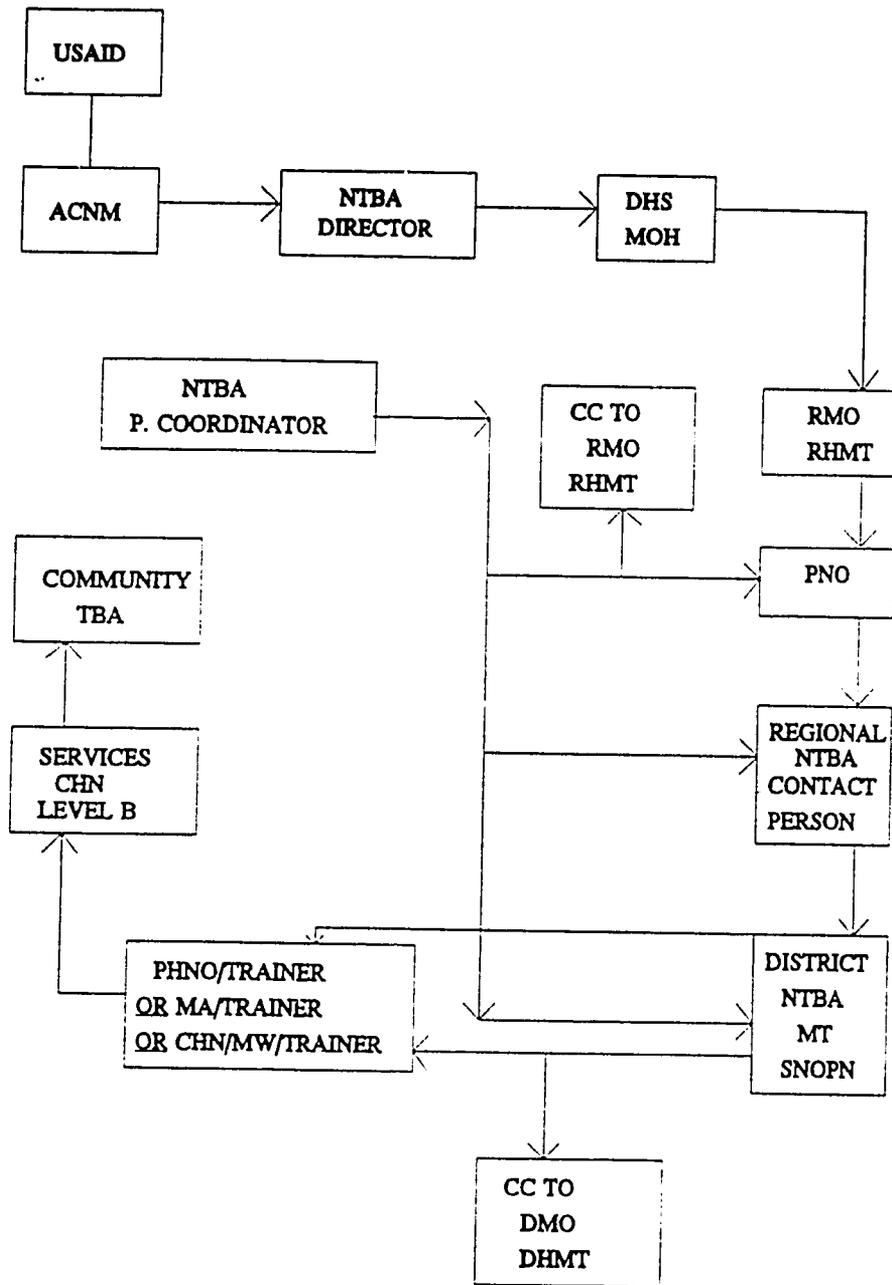
NTBA communications should go through official MOH, RHMT and DHMT channels to stimulate the awareness and broaden support for NTBA programs. NTBA should assure this for the planning, supervision, data collection and analysis, and supplies distribution activities, all of which will need to be eventually sustained and incorporated within the MOH structure.

4.9 Program Planning, Monitoring and Evaluation System

The NTBA has developed no project plan or annual plan. The emphasis of NTBA activities have been heavily focused on initiating training and developing training materials. The overview of the entire program plan as an overview with interrelated clinical, training and management components is a key tool needed to plan and coordinate the complex NTBA program. This program plan was not found at NTBA.

NTBA has also not developed a formalized management and monitoring system, although this would allow NTBA to monitor the progress of integrating the numerous program components. Again, emphasis was placed on developing the initial training while other related program systems lagged behind. Likewise, no NTBA Regional Plans have been developed that would document and guide the region's various TBA training, management and support activities. None of the ACNM/NTBA original program objectives in the scope of work specifically called for planning, monitoring or evaluating overall NTBA program.

Figure 5
NTBA Communications System



POINTS OF CLARIFICATION

- * Official Communication from NTBA follows official MOH Communication channels
- * Communication from training coordinators tends to follow MOH official channels within nursing and MCH hierarchies

Recommendation

ACNM, NTBA and USAID Ghana should develop a monitoring system based on a limited number of management indicators that will quickly but effectively indicate the status of the program. (See Appendix D for the indicators developed for NTBA program management.)

4.10 Structure and Responsibilities for the Future NTBA Program

The new management structure and advanced level of responsibilities shown in Figure 6 should be implemented in the future. It has been proposed and discussed with NTBA staff and MOH officials. This new organizational structure is designed to upgrade the NTBA staff, with expanded program and management responsibilities. Specifically, it redefines the NTBA, with the role to provide technical and managerial assistance to the MOH at central and regional levels. The NTBA would no longer have direct line authority but instead would play an advisory role vis-a-vis the Regional and District Medical Officers, RHMTs, and DHMTs. In the new structure, the RHMTs and DHMTs assume direct responsibility for implementing the NTBA activities. The NTBA assumes the responsibility for planning, managing, monitoring and evaluating the future nationwide program and coordinating the MOH's implementation of it. (A task analysis as a basis for new, more detailed job descriptions was initiated during the evaluation and is included in appendix C.)

The proposed organizational chart would also align the NTBA within the MOH operational structure, following MOH lines of authority, referral, communications, supply. When the proposed reorganization of the MOH at the central level is implemented, the MOH and the NTBA will need to define the relationship of the NTBA with the Manpower and Training, Maternal Child Health and Health Information Systems divisions.

The NTBA Program Director will continue with program oversight and planning and monitoring responsibilities and continue to report to the MOH Director of Health Services. The Project Administrator position, designated as Program Manager, will assume an expanded role to plan, develop, manage, administer, and monitor overall NTBA program and systems. She would take day-to-day responsibility for both the Program and Administration departments and supervise all NTBA staff. The Program Trainer positions would change to Program Coordinators, with expanded responsibilities for specific systems to plan, manage and monitor. An Administrative Assistant should be hired, if needed, to handle administrative systems under the guidance of the Program Manager.

In the future NTBA program, ACNM will provide advanced management and training systems development in addition to clinical expertise. A new scope of work for the ACNM (see appendix D) defines skills

and tasks to be done by ACNM program staff and short-term technical advisors. Although emphasis is placed on the Program Director position description, additional TA categories have been outlined as time permitted. Future TA in the areas of project planning, monitoring and evaluation, competency-based training, materials development, HIS, and supplies management should receive priority. It is recognized that competent local and international TA will be crucial to future Program success.

(In addition, a Program Action Plan is included in Appendix D to provide guidance on the development of the future program.)

Recommendations

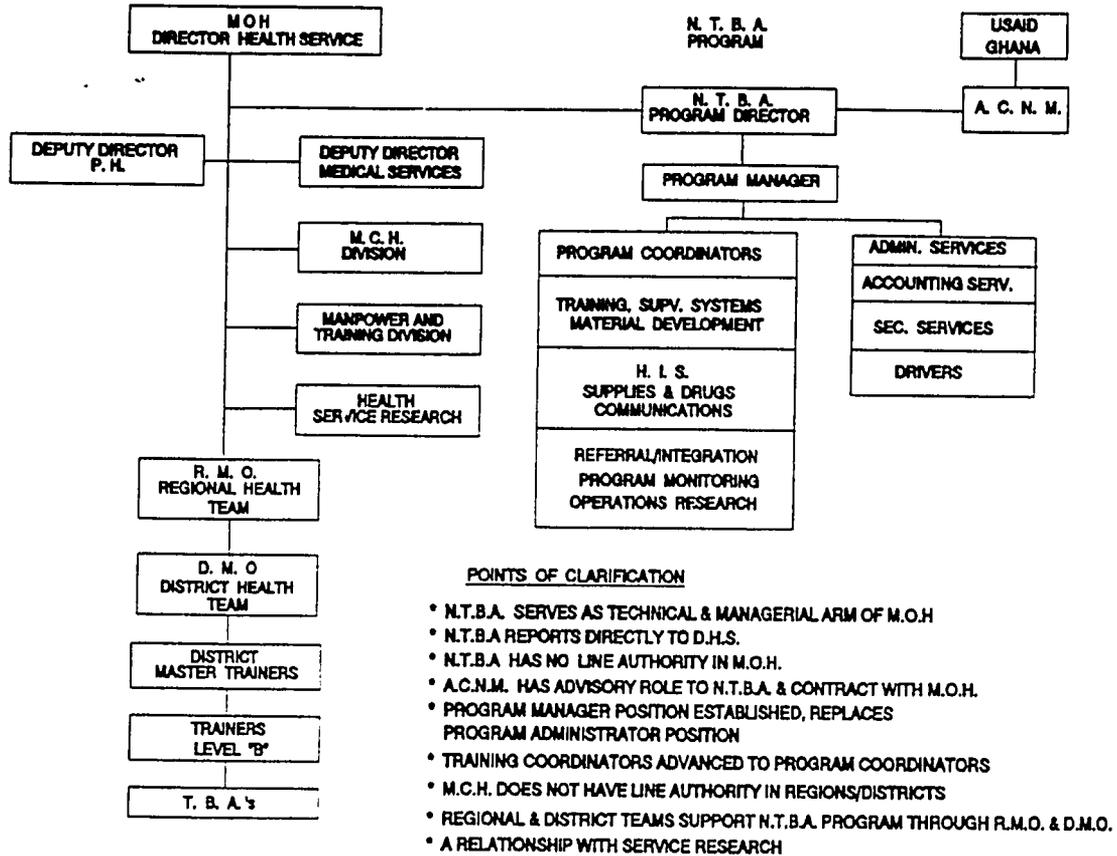
- The proposed NTBA organizational structure (see Figure 6) should be implemented which will expand programmatic and management responsibilities for NTBA staff as technical support to MOH central and regional teams implementing TBA training, supervision and support.

- ACNM should also implement the expanded SOW and local technical assistance should build NTBA and MOH core capability and management systems to develop sustainable management support systems. Additional short intensive courses for NTBA core staff should also be considered.

- The draft first year Action Plan should be revised and implemented to initiate program activities.

Figure 6

Proposed NTBA Reorganization



5. Comparison of USAID-Supported with Other Donor Supported Regions

The Evaluation Team visited a region supported by another donor to attempt to assess variations in program performance related to difference in source of funding. Time limitations did not allow an in-depth comparison, but several factors did appear to influence program activities. They include the following:

- the USAID supported regions are more likely to receive their funding sufficiently in advance to prepare and fund training activities. USAID funding is also allocated over a longer period of time to allow regions to project activities.
- funding for support visits to the regions for follow-up has been more adequately funded by USAID.
- funding from other donors has gone directly to the regions, resulting in delays in transferring funds back to NTBA for support visits.
- USAID-supported regions had generally more funding for manuals for training and orientation of MOH staff. Funding shortages in other regions reportedly caused manuals used to orient MOH staff to be collected after the sessions so that they could be shared with the next group to be oriented.
- The emphasis on use of uniform guidelines across all regions is reported to have somewhat stifled RHMT and DHMT interest in innovations and ownership of the NTBA program by them.
- the DHMTs that had participated in the Strengthening District Health Systems Initiatives based on PHC workshops (MOH/WHO initiative) appeared to have acquired the basic planning, management and monitoring skills which helped them implement NTBA training and provide later support.

6. Operations Research

Although an OR project was used to develop the methodologies and guidelines for the Ghana-wide implementation of TBA program (see Section 1.2), no OR has been directly funded by the NTBA program since the program itself got under way (1989-1992).

OR will, however, be included as an integral part of the future TBA program, although it will be incorporated as part of the activities, structure, and responsibilities of the regions. The OR will focus on small "test efforts" in health services, training, and clinical aspects which are being carefully considered for innovation by regions. They will be reviewed by NTBA and MOH.

The current MOH approach maintains a uniform workable NTBA system of training and support which will continue for the basic core of NTBA elements. The approach will, however, be modified to allow small, well-conceived, monitored, and reported tests of the NTBA model to improve the NTBA Program. This OR approach will encourage MOH regions and districts to examine their programs, to adapt the program to local needs, and to report the results of their tests in a larger forum. This OR should increase their sense of "ownership" of the TBA program and encourage ongoing analysis and improvement of the program.

Recommendation

OR should be funded at a modest level by the program to encourage ownership and innovation by region and adaptation to local needs and conditions. Alternatively, MOH recognition and encouragement of tests could be encouraged as an expected yet applauded part of regional staff's work.

This type of OR is needed to strengthen NTBA management systems at all levels. Several specific areas of study could include the following: assess client and community response to TBA distributions of oral contraceptives, compared with TBA referral to MOH facilities for this service; test a mix of MOH and private supply systems to assure consistent supplies to TBAs including oral contraceptives; test "community messenger" systems to increase communication between TBAs and MOH staff and involve communities; test models of nutrition education and iron supplementation to increase iron levels in women; test TBA to TBA models and team teaching models (peer training) and processes for skills improvement; test an intensive supervision model to assess the potential for decreased initial training in favor of on-going supervisory training. The cost, time, methods, and results of these new models need to be documented and compared with previously used NTBA training model.

7. Sustainability Issues

7.1 Financing Mechanisms and Channels

MOH use of donor funding to initiate NTBA training activities has allowed initial and, in some cases, refresher training. It has also funded NTBA core staff to initiate, manage and monitor the Program. Continuation of donor funding for core NTBA staff is anticipated for the future Program and funding for essential office equipment and supplies. For the USAID-supported regions, dollar grant funds will be made available to the ACNM for technical assistance and off shore procurement.

Local costs are expected to be borne out of the MOH budget. USAID will provide Cedi support to the MOH budget to ensure that this is fully funded. This is intended to ensure NTBA Program sustainability in creating a line item presence. USAID plans to provide funds to the Ministry of Finance and Economic Planning (MFEP) to be passed to the MOH. This mechanism (creation of the TBA line item) is designed to encourage sustainability of the TBA activities after the future Program is terminated.

The MOH states that passing funds through the MFEP will cause delays and will, in fact, decrease the total amount of money made available to MOH PHC programs. At the time of the Evaluation, the MFEP was setting fund release ceilings at 33 percent of budgeted amounts. Ministry officials estimate that this could cause a 18- to 24-month delay in implementation. It currently affects local travel costs for outreach MCH and other PHC activities and is reportedly partially responsible for the recent drop in immunization coverage. An 18- to 20-month delay could seriously affect the NTBA Program.

On the other hand, USAID representatives point to the success of the Primary Education Project (PREP) where, because of Mission intervention, MFEP fund releases have been complete and timely.

Recommendation

Mechanisms for the channelling of NTBA funds should be discussed between USAID and GOG/MOH to assure that the goal of long-term sustainability is achieved without the schedule for NTBA Program implementation being extraordinarily delayed.

7.2 Institutionalization for Sustainability

NTBA and MOH will need to develop core capabilities to plan, manage, monitor and evaluate the NTBA program. This is crucial to sustainability of TBA activities. Strengthening RHMT and DHMT skills and responsibilities to fully implement training and management systems is also important. Broadening the number of

RHMT and DHMT members involved in TBA activities will help them assume ownership of the TBA program and incorporate it within their regional and district plans and budgets. This is vital to long-term ownership and sustainability. Strong technical guidance from NTBA and international TA advisors can be joined with regional and district team efforts to experiment with innovative, low-cost, high-quality training and supervision models which can be sustained.

Recommendation

The NTBA and MOH should develop sustained institutional capability at the central, regional and district levels to plan and implement TBA activities. Innovative training and supervision models should be explored which allow continued low-cost, high-quality training, supervision and management systems to be continued within regional and district plans and budgets.

7.3 Community Participation for Sustainability

Rural communities recognize the importance of the skills and safe practices of NTBA-trained TBAs. Community leaders expressed willingness to support the TBA program. They often set fees for TBAs and help them with farming and other chores. Some communities have built a room for the TBA to conduct deliveries. Other assistance from the community may be needed to assure that TBAs continue to practice, as the fees for TBA services are generally modest. High levels of community involvement will help assure their ownership and long-term sustainability of TBAs in rural areas.

Trained TBAs want additional training and are willing to share training costs with NTBA. Untrained TBAs also offered to help pay for their initial and follow-on training. Currently TBAs pay for transport for their follow-on training. Since TBAs are essentially private practitioners, seeking additional training can be stimulated by the "profit motive." This has implications for their sharing costs with NTBA.

Operations research has not yet been conducted to assess fully the capability of communities to support and "supervise" TBAs and for TBAs to share training costs.

Recommendation

NTBA should encourage communities to be even more actively involved in the support (financial and other) for training, supervision and the ongoing practice of TBAs. Small operations research assessments should be done to identify community capability to help their TBAs, "supervise" them and to financially support TBA training and activities. The individual TBA's capability to share training and supervision costs and help train other TBAs should

also be assessed as a method to decrease costs, but more important, to increase their ownership and ensure sustained TBA services in rural communities.

Appendix A

The Evaluation

Team Scope of Work

Summary of Questions

Team Composition

List of Documents Reviewed

List of Contacts

Map of Ghana

The objectives of the project are:

- (A) To establish a national secretariat to coordinate, monitor, support and evaluate the TBA training program against specific national guidelines.
- (B) To develop a uniform and workable support system for trained TBAs which includes supervision, supplies, record-keeping, referral and refresher training.
- (C) To orient health personnel and the communities concerned with the program and its purpose.
- (D) To select and train TBA training coordinators in the Volta, Northern, Upper West, Brong-Ahafo and Central Regions.
- (E) To identify, select and train up to eight master TBA trainers in each of the five regions.
- (F) To identify, select, and train up to sixty TBA trainers from Level B (Health Center Level) in each of the five regions.
- (G) To provide all necessary financial and material support for each Level B trainer to train a minimum of ten TBAs (minimum total to 600 TBAs have been trained per region).
- (H) To implement and complete training of TBAs in five of Ghana's ten regions which have been selected based on established criteria.
- (I) To assist master trainers and Level B TBA trainers to establish and maintain an inventory of TBAs in their respective areas, with information on the TBAs' current status, training, performance and the services they provide.

Evaluation activities: The evaluation team should focus attention on the following issues: Project impact, sustainability and lessons learn for adaptation in future projects and should address the following questions:

- (A) Assess project progress/accomplishments to date under the grant agreement. Establishment of national secretariat to coordinate, monitor, support, and evaluate the national TBA program.

Selection and appropriate training of regional TBA training coordinators in the regions selected for training.

- (1) Evaluate the functioning of the complete system that incorporates national, regional and district levels.
- (2) Evaluate the scope, functions, and effectiveness of the national and regional structures performing the following activities:
 - A. Training
 - B. Management Support
 - I. Personnel
 - II. Communication
 - III. Record Keeping and Reporting
 - - Activity
 - - Financial
 - C. Equipment/Supplies at Level B
 - D. Transport

- E. Supervision
 - F. Monitoring and Evaluation
 - G. Short and Long Term Planning
- b. Implementation and completion of training of master trainers, TBA trainers, and TBAs in five of Ghana's ten regions:
- (1) Document number trained in each category, and assess the adequacy of the selection process in identifying appropriate people to implement the project.
 - (2) Evaluate materials developed:
 - A. What training materials were developed
 - B. Were the training materials developed in an appropriate and innovative manner given the level of participants trained.
 - (3) Evaluate variety and appropriateness of teaching methodologies used for level of participants trained.
 - (4) Evaluate quality of training
 - A. Document evidence of successful transfer of essential knowledge and skills.
 - B. Trainees' perceptions of training.
 - C. Trainees' ability/desire to use new knowledge and skills.
 - (5) Evaluate process and structure of implementation and completion of training in each region, including quality of training teams.
- C. Development of a uniform and workable support system for trained TBAs, including mechanisms for supervision, provision of supplies, record keeping, referral and continuing education:
- (1) Document what support systems/mechanisms have been established.
 - (2) Document number of participants, by category, in continuing education activities.
 - (3) Evaluate integration of support systems/mechanisms in overall program.
 - (4) Evaluate effectiveness of support systems/mechanisms.
- D. Conduct ongoing operations research/evaluation activities and use of finding to improve the program.
- E. Development and production of appropriate health education materials for non-literates to support TBA training (in collaboration with the MOH Health Education Division and possibly Johns Hopkins University/Population Communications Services).
- II. Assess project management on the part of MOH, ACNM, and USAID. If possible, compare with management in regions supported by UNICEF and UNFPA:
- III. Assess completeness of project design and assumption:
- A. Assess the TBA's role in family planning (FP) and other primary health care (PHC) activities (based on the project assumption and MOH policy of TBA's role):

- (1) Does the TBA see herself as a FP/PHC service provider? Does she see herself as having enough time to provide FP/PHC services?
 - (2) Does the community see a role for the TBA as a FP/PHC service provider? Does the community recognize the knowledge and skills of the TBA following the training?
 - (3) What skills do TBAs need to assume a larger role in FP/PHC service provision (increased education, community awareness/support, other support, supplies, other FP methods)?
- B. Assess importance of support/supervision to project success to date.
- (1) Assess the effect of MOH record keeping, reporting, and monitoring capabilities on project impact in this area; suggest alternative ways of improving these capabilities through national TBA program activities.
 - (2) Assess the effect of resource (human and material) availability at level B and district levels on frequency and quality of supervision/support visits; suggest alternate ways of promoting these visits.
- C. Assess the impact of technical assistance provided by the American College of Nurse-Midwives.
- (1) Was the level of effort appropriate for achieving the project objectives? What level of effort will be required in a follow-on project?
 - (2) Was the technical assistance appropriate for achieving the technical assistance? How will technical assistance differ in a follow-on project?
 - (3) How well were research and evaluation issues addressed in the project?
- D. Assess the impact of MOH policies regarding decentralization and integration on project success to date:
- (1) What efforts were made to promote decentralization and integration of the project into existing MOH activities and systems, at all levels of the MOH?
 - (2) To what extent did existing MOH activities and systems affect project success?
- IV. Assessment of project impact (the mission recognizes that this will be largely anecdotal since quantitative data will be difficult to obtain):
- A. Assess how training and supervision of master trainers and TBA trainers has brought about changes in their work:
- (1) As members of health care teams within given facilities.
 - (2) As managers of health services delivery.
 - (3) As FP/PHC health service providers:
 - A. Technical knowledge and skills.
 - B. Health education, counseling, and motivation knowledge and skills.

(4) As representatives of the MOH at the community level.

B. Assess how training and supervision of TBAs has brought about a change in activities related to her work as a TBA:

(1) Provision of antenatal care.

(2) Referral of routine antenatal cases of assessment and tetanus toxoid immunization.

(3) Labor and delivery practices.

(4) Provision of postnatal care.

(5) Referral of routine postnatal cases for registration and immunization of infants.

(6) Identification and timely referral of high risk and complicated cases.

(7) Provision of education about and distribution of FP/Oral Rehydration Therapy (ORT) methods.

(8) Use, storage, and replenishment of supplies.

(9) Record keeping.

C. Assess how training and supervision of TBAs, TBA trainers, and master trainers has brought about a change in relationships:

(1) Has the image and role of the TBA changed in the community, among professional private sector midwives, and among MOH staff?

(2) Have there been changes in attitudes of TBAs about supervisors and supervisors about TBAs?

(3) Are TBAs seen as a more integrated part of the total health system by the community, themselves, private sector midwives, and MOH staff? In what way?

(4) Have there been any changes in attitudes of private sector and public sector midwives about their counterparts in the other sector?

V. Provide recommendations in each of the areas listed above to be incorporated into a follow-on project. In addition, address the following issues:

- Considering the level of TA provided by ACNM to the national training coordinators, training materials and project vehicles, how can MOH continue with the support of the monitoring and supervision of master trainers, trainers and TBAs to ensure that proper standards are maintained?

- What level of funds will need to be provided in the overall MOH budget to the NTBA program budget to ensure the continuity of program activities?

Summary of Questions

The evaluation addressed seven basic questions:

1. To what extent have the goal and objectives as stated in the grant agreement been met?
2. Was the process used in the goal attainment efficient and effective?
3. What were the major unforeseen outcomes that have positively or negatively impacted the program?
4. What is the impact of the program?
5. What have been the major deficiencies in program implementation to date?
6. What needs to be done to improve the overall efficiency and effectiveness of the program and the productivity of TBAs and supervisors/trainers?
7. How can the sustainability of the program be assured?

Team Composition

Rose M. Schneider RN MPH Team Leader Management systems Specialist

Tom Coles Jr. MPH Training Specialist

Margaret Price PhD. Clinical Specialist

Sam Adjei MD MPH Director NTBA Secretariat

Patricia Odoi Nursing Officer (PH) NTBA Program Secretariat Training Component Evaluator

Andy Borkley Technical Officer (CDC) NTBA Program Secretariat Training Component Evaluator

Rejoice Nutakor SRN, CMB, CPHN, MCOMMH MPH Management Component Evaluator

List of Documents Reviewed

1. **National Traditional Birth Attendants
Program Guidelines
November 1988
Revised June 1989
Produced by the Ministry of Health
Ghana with Assistance from USAID, Ghana**

2. **Trainers' Manual for the training of traditional birth
attendants in Ghana February 1990
Produced by the Ministry of Health, Ghana, with
assistance from USAID/GHANA and the American
College of Nurse Midwives.**

3. **A Manual for the training of traditional birth attendants
in Ghana Volume three.
Produced by the Ministry of Health, Ghana, with assistance
from UNICEF and USAID, GHANA.**

4. **A manual for the training of traditional birth attendants
in Ghana. Volume one.
Produced by the Ministry of Health, Ghana with assistance from UNICEF and USAID, GHANA.**

5. **A manual for the training of traditional birth attendants in Ghana. Volume two.
Produced by the Ministry of Health, Ghana with assistance from UNICEF and USAID, GHANA.**

6. **Final report Operations Research Project. Family Planning Care by Traditional Birth Attendants.
June, 1990.
Ministry of Health
P.O.Box M-44
Accra, Ghana
West Africa**

Center for Population and Family Health Columbia University 60 Haven Avenue New York, New York, 10032 U.S.A.

7. **Training manual in ----- and outreach for traditional birth attendants. By Patience Cofie
May 1990.
Ministry of Health (Accra)**

8. **Family Planning and Counselling Module for Health Centers Primary Health Care Program
Ministry of Health - Ghana 1989**

9. **Ministry of Health/Columbia University Operations Research Project "Delivery of PHC services
by TBAs in rural Ghana"
Report on the baseline survey
Prepared by Dr. Sam Adjei Principal Investigator, Therese McGinn, M.P.H. Technical Advisor
Accra, Ghana.**

10. **Scope of work. Cooperative Agreement between USAID and the American College of Nurse-
Midwives supporting Ghana Registered Midwives and traditional birth attendants.**

11. **Ghana National Traditional Birth Attendants Program**
 Grant No. AFR-0462-G-SS-9049-00
 Grant No. AFR-0462-G-SS-9031-00
 Project Summary. Prepared for evaluation of Ministry of Health/American College of Nurse
 Midwives Ghana National Traditional Birth Attendant Program
 Submitted by American College of Nurse-Midwives
 Special Projects Section
 1522 K Street, NW
 Suite 1000
 Washington, DC 2005.
 March 13, 1992
12. **Data Bank on trained TBAs**
 National TBA Program
 Ministry of Health, 1990.
13. **Monthly TBA Return Form**
 Ministry of Health, 1991.
14. **Report on T.B.A training program**
 Atwima District Ashanti.
 District Health Management Team,
 Ministry of Health
 P.O.Box 17
 Nkawie,
 9th January 1992.
15. **Report on Training of Traditional Birth Attendance Program held in the Nwabiagya No. 2 Health Area**
16. **CPFH/MOH/OR VOLTA REGION**
 Supervisors Evaluation
 National TBA Coordinators
 Routine Support Visit. 1990.
17. **Monthly T.B.A. Summary Sheet**
 Month January 1990.
 Ministry of Health.
18. **Presentation to the Annual Meeting of the American Public Health Association New York City**
 September 30 - October 4, 1990.

 Expanding the pilot project to the nation: the case of the Ghana TBA Program
 Authors Therese McGinn, Center for population and Family Health Columbia University; Sam
 Adjei, Ministry of Health, Ghana, Marsha Dupar, American College of Nurse-Midwives
19. **Agency for International Development Washington D.C. 20523**
 Action memorandum for the assistant administrator for Africa.
20. **National MCH/FP Semi-Annual Workshop**
 Akim Oda, Eastern Region
 September 2 - 6, 1991.
 Ministry of Health.

53

21. **Maternal and Child Health/Family Planning
1990 National Report
Ministry of Health**
22. **Traditional Birth Attendants. Review Program in Ghana.
by Professor P.A. Twumasi
Commissioned by Ministry of Health.
October 1987.**
23. **National TBA Program
Draft Report of Mini-Surveys of Village Women,
Volta Region, 1990-1991.
Draft Report prepared by Therese McGinn, M.P.H.
September 5, 1991.
Telephones (212) 686-3110 ext. 174 (days)
(212) 529-2283 (evenings)
Fax (212) 532-6162.**
24. **National Traditional Birth Attendant Program
Ghana. Report on Brong-Ahafo Region
May 1990 - November 1991.**
25. **Maternal and Child Health and Family Planning -C/Region
Annual Report. January - December, 1990.
Ministry of Health**
26. **Maternal and Child Health and Family Planning
Annual Report 1989
Ministry of Health**
27. **Project Grant Agreement between the republic of Ghana and the United States of America for
Family Planning and Health.
A.I.D. Project No. 641-0118
Date April 25, 1991.**
28. **Report on National Traditional Birth Attendants Program
July 1989 - December 1990.
Ministry of Health**
29. **Population Technical Assistance Project
1601 N. kent St. Suite 1014
Arlington, Va 22209
Tel (703)243-8665 Telex 271837 ISTI UR Fax (703)358-9271**
30. **Cosmopolitan Obstetrics Some insights from the training of traditional Midwives**
31. **Agency for International Development
Project Paper (PP) and Program Assistance Approval Document (PAAD). Ghana Family
Planning and Health Program (FPHP)
Unclassified. Office of A.I.D. Representative Ghana.**
32. **Progress Report on the Reorganization of the Ministry of Health. Prepared by B.C. Eghan
Adviser, Reorganization of the Ministry of Health. March 1991.**

33. **Policy Framework for PHC Management Training in Ghana.**
S. A. Amoa Acting Deputy Director (Training)
G.I.M.P.A.
Part 1 of Management audit reports: March 1988
Commissioned by the Ministry of Health, Ghana.
34. **Management audit of Ada and Ejuso-Juabeng-Bosomtwe districts**
S.A. Amoa. Acting Deputy Director (Training)
G.I.M.P.A.
Part 2 of Management audit reports: March 1988
Commissioned by the Ministry of Health, Ghana.
35. **Maternal and Child Health/Family Planning 1991**
Annual report Volta Region.
Ministry of Health.
36. **Trip Report. Ghana**
Grant No. AFR-0462-G-SS-8049
Grant No. AFR-0462-G-SS-9031
Marsha Dupar, CNM, MPH
April 28-June 11, 1989
Helene Rippey, CNM MS
April 28-May 13, 1989
Mary Ellen Stanton, CNM, MSN
April 28-May 5, 1989.
37. **American College of Nurse-Midwives**
Special Projects Section
1522 K. Street, N.W. Suite 1000
Washington D.C. 2005
38. **Trip report. Ghana.**
National program for traditional birth attendants.
Grant No AFR-0462-G-SS-9031-00
Grant No AFR-0462-G-SS-8049-00
Marsha Dupar CNM MPH
June 1 - 20, 1991
July 6 - August 2, 1991
39. **American College of Nurse-Midwives**
Special Projects Section
1522 K Street N.W. Suite 1000
Washington, D.C. 2005

List of Contacts

The following list, although extensive, does not capture all those with whom we spoke. For those whose names we have omitted, apologies are offered. We wish to thank all those who shared their time and information with us.

1. Dr. Sam Adjei
Director (HRU)
Adabrka Polyclinic
2. Dr. Moses Adibo
Director of Medical Services
Ministry of Health.
3. Ms. Vivian Oku
Nursing Officer (PH)
Adabraka Polyclinic
4. Ms. Rose Akita
PNO Officer
Adabraka Polyclinic
5. Mr Andy Bortey
Communicable diseases
Adabraka Polyclinic
6. Ms. Patricia Odoi
Nursing Officer
Adabraka Polyclinic
7. Ms Elizabeth Odoi
Nursing Officer (PH)
8. Ms. Mary Ansomah
SEN/M
9. Ms Sara
CHN/M
Prampram
10. Ms Sabina
CHN/M
Prampram
11. Auntie Sara
12. Ms Lydia Dzpegrodur
SMA
13. Mr. Divine Kudjoru, MA
Prampram

14. **Ms Attia Mensa
SCHN/M
Chiraa District**
15. **Ms Rosina Yeboah**
16. **Ms Judith Addoquaye
SNO/(PH)**
17. **Ms Elizabeth Abaafi
SNO(PN)**
18. **Ms Theresa Boateng**
19. **Ms. Rebecca Dormo
SNO (PH)**
20. **Ms Dorcas Boateng
Private Midwife**
21. **Ms Paulina Bazaabon
PHN**
22. **Ms Comfort Annor
SCHN/M**
23. **Ms Elizabeth Adu-Boahene
No (PH)**
24. **Mad Akosua Tiwaa**
25. **Mad Margaret Offei
SNO (PH)**
26. **Mad Josephine Comwell
SCHN/M**
27. **Mad. Comfort Wilson
SEN/M**
28. **Mad. Georgina Emisang
SCHN/M**
29. **Dr. Mohammed Bin Ibrahim
DMO Effiduase**
30. **Dr. Luther Zogli
DMO Nkawie**
31. **Ms Gertrude
NO (SRN)**

BRONG AHAFO

1. SUNYANI DISTRICT

Dr. Nii A; Coleman, SNO (PH)
Mr. Enoch A. Odamteng, Regional Hospital Secretary
Miss Theresa Boateng, SNO (PH), Master trainer, MCH Centre
Miss Theodora Okyere, NO (PH), TBA trainer, MCH Centre
Miss Margaret Konadu, SCHNM, TBA trainer
Miss Marion Frimpong, NO (PH), Master trainer
Miss Rosina Yeboah, SCHNM, TBA trainer, Chiraa Health Centre
Miss Ataa Mansah, MA, Chiraa Health Centre

2. WENCHI DISTRICT

Dr. Yeboah Antwi, DMO, Methodist Hospital
Doris A. Boye, PHN, Methodist Hospital
Elizabeth Abrefa, Midwifery Sup., Gov't Maternity Home, Wenchi
Felicitus Kunwill, SCHNM
Margaret Saarah, TBA trainer, Badu Gov't Maternity Home
Nana Kwaku Mmoro, Chief, Tainso
Kwadjo Awuah, Krontihene, Tainso

3. TECHIMAN DISTRICT

Judity Addoquaye, SNO (PH), Assistant RCP, MCH Centre
Rebecca Dorno, SNO (PH), Master trainer, Holy Family Hospital
Elizabeth Yeboah, SENM, TBA trainer, Holy Family Hospital
Dr. Boateng, DMO, Holy Family Hospital
Gertrude Maasang-yir, NO (SRN), TBA trainer, Holy Family Hospital
Dorcas Boateng, Private Midwife, TBA trainer
Rosina Oppong, SCHNM, TBA trainer, Tanoso Health Centre
Christine Antor, PHN, MCH Centre, Techniman
Samuel Osei, MA, Tanoso Health Centre

4. KINTAMPO DISTRICT

Dr. Sam Ackor, DMO
Margaret Nmini, NO (PH), Master trainer, Kintampo
Paulina Bazaabon, PHN, TBA trainer, Kintampo
Comfort Annor, SCHNM, TBA trainer, Kintampo
Mr. , MA, Kintampo

ASHANTI REGION

Mr. Yao Munifie, Administrative Assistant, Kumasi
Comfort Ansong, PHN, Kumasi

1. SEKYERE EAST DISTRICT

Dr. Mohammed Bin Ibrahim, DMO, Effiduase Health Centre
Elizabeth Adu-Boahen, NO (PH), Master trainer, Effiduase

Agnes Ackom, PHN, Effiduase Health Centre
Elizabeth Atta-Mensah, Midwifery Sup., Effiduase Health Centre
Grace Pomaa Marfo, trained TBA, Banko village
Anna Addai, trained TBA, Dadeaso

2. KWABRE DISTRICT

Grace Ottih, CHNM, TBA trainer, Mamponenten
Mr. J. Asoma-Djan
Akosua Tiwaa, trained TBA, Adwumam village
Esther Nkruma, trained TBA, Bosore

3. ATWIMA DISTRICT

Dr. Luther King Zogli, DMO, Nihenine Health Centre
Margaret Offei, SNO (PH), Master trainer, Nkawie Health Centre
Bernard Y. Fosu, TO (CDC)
Mary Akakpo, SCHNM, TBA trainer, Nihehine Health Centre
Margaret Brown, SCHNM, TBA trainer, Abuakwa Health Centre
Georgina Nyarko, trained TBA, Abuakwa
Afia Owusua, trained TBA, Msensi

CENTRAL REGION

Dr. R.Y. Osei, Reg. Director of Health Services
Gladys Adjakuma, PNO (PH), Assistant RCP, Winneba

1. MFANTSIMAN DISTRICT

Diana Hall-Baidu, SNO (PH), Master trainer, Saltpond
Josephine Cromwell, SCHNM, TBA trainer, Otuam
Comfort Wilson, SENM, TBA trainer, Saltpond
Georgina Emisang, SCHNM, TBA trainer, Saltpond
Mr.J.K. Badu, SEN, Saltpond
Florence Ottoh, SCHNM, TBA trainer, Essuehyia
Agnes Reynolds, SENM, Anumabo

2. AWUTU, EFUTU BEREKU SENYAU

Gloria Vanderpuye, SNO (PH), MCH/FP Centre, Winneba
Mrs. Mercy Hanson, Private Midwife, Mercy Maternity Home, Winneba
Sophia Yamoah, Private Midwife, Bethel Maternity Home, Winneba
Mr. Samuel Odum, TO (CDC), DHMT member, Winneba
Mr. J.C. Ayitey, TO (ENVIRONMENTAL), DHMT member, Winneba
Mr. George Akitiwah, TO (NUTRITION), DHMT member, Winneba
Mr. Kofi Afedzi, Assemblyman, Dwomba East, Winneba
Mr. R.R.R. Amponsah, Zonal Secretariat, CDR, Winneba
Mr. Stephen K.A. Bortsie, ZOA CDR, Winneba

GOMOA DISTRICT

VOLTA REGION

Dr. E.N. Mensah, RDHS, HO

Dr. A.Y. Letsa, SMO (PH), Regional Health Administration, HO

Miss Regina Cudjoe, RCP, Regional Health Administration, HO

1. HOHOE DISTRICT

Dr. C. Oppong-Yeboah, DMO

Miss Adolphine Iglaku-Acquah, SNO (PH), Master trainer, Hohoe

Mrs. Regina Asare, PNO (EDUCATION), Master trainer, Hohoe

Miss Blandina Okrah, SCHNM, TBA trainer, Akpafu Mempeasem

Mr. Rex Adzableh, DHMT, Sec.

Mr. Ben Kettey, Senior Technical Officer (CDC), DHMT member

Mr. Morgan Agbi, Senior Field Technician (CDC), DHMT member

Mr. G.K. Agordzo, Environmental Technologist, DHMT member

Mrs. Joana Doe, Senior Technical Officer (NUTRITION), DHMT member

2. KPANDO DISTRICT

Dr. Amenuve Bekui, DMO

Miss Grace Awalime, Midwifery Sup., Kpando

GREATER ACCRA REGION

Divine Kudjonu, Medical Assistant, Prampram Health Post

Elizabeth Odai, NO (PH), TBA trainer, Health Post

Mary Ansomah, SENM, TBA trainer, Health Post

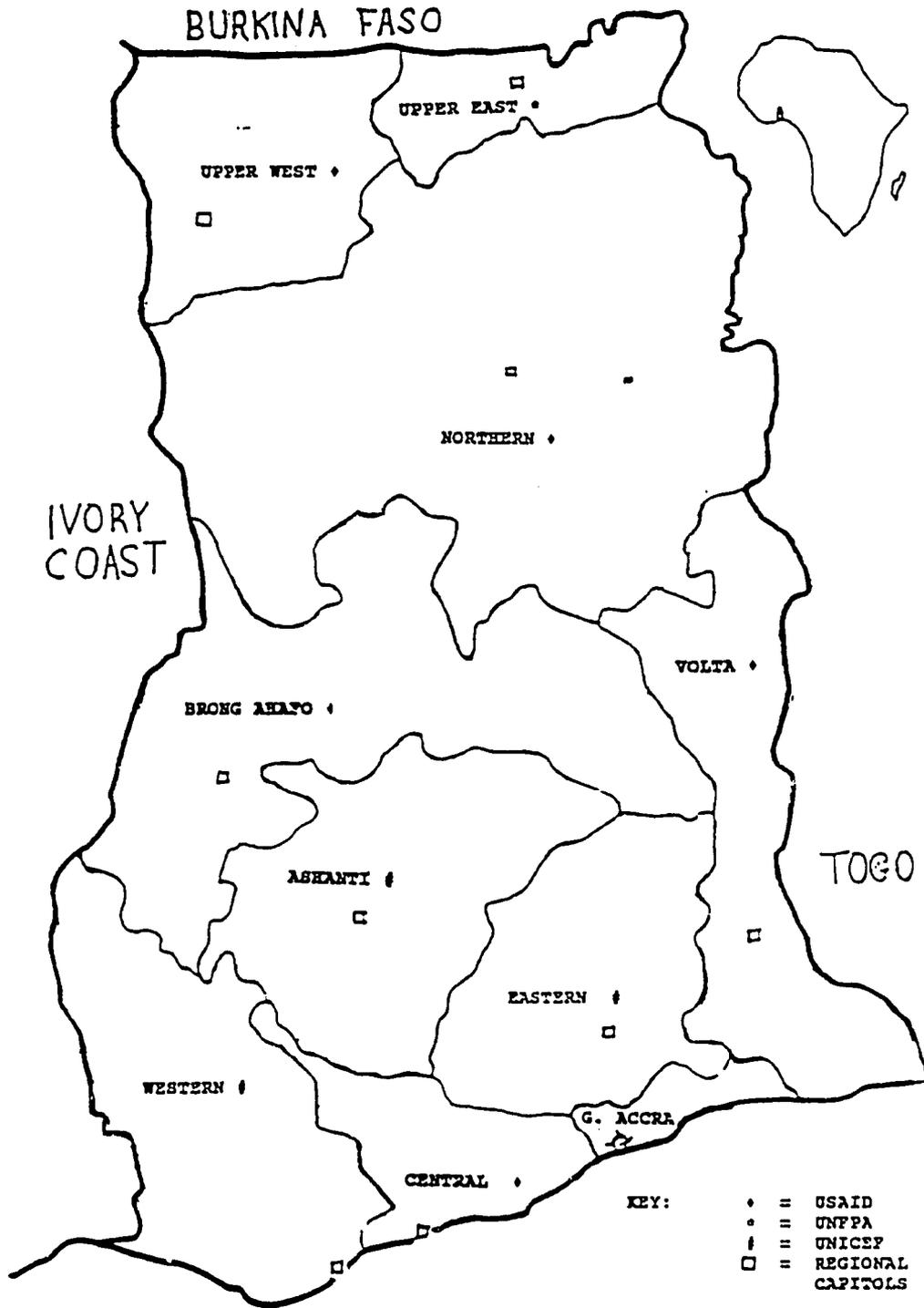
Mariama Tetteh, trained TBA, Dwahenya

Sarah Tagoe, trained TBA, Afiencya

Sarah Balm, PHN, Dodowa Health Centre

Lydia Dzragbodor, trained TBA, Agomeda

Map of Ghana



Appendix B

Clinical

Focus Group Discussion Summaries

TBA Kits

Focus Group Discussion Summaries

Summary

No. 1 Focus Group Discussions Trained TBA

1. Expectations and Needs

1.1 All groups felt that they were taught most of what they expected to learn when they went for training. Expectations which were met included: supervised delivery in a health facility, proper separation and care of the baby's cord, nutrition of the mother and baby, family planning, immunizations and types of diseases they prevent.

1.2 Unmet expectations which still exist include: giving drugs for headache; treatment of minor ailments e.g., dizziness during pregnancy and after delivery; the use of gloves and disinfectant for delivery; foetal auscultation, use of B/P apparatus; emptying the airway through suction and resuscitation of newborn babies; prevention and treatment of AIDS; treatment of snake bites and oedema of the feet; the use of drugs like ergometrine in treating post partum hemorrhage. They also expressed the need to know more about the management of post partum hemorrhage; breech presentation prolonged labor and bleeding cord.

2. Training:

2.1 The consensus response from all groups was positive. Training has been of real value. Reasons given related to satisfaction with the skills they received and the value of these skills to themselves and the community. For example they are now able to attend to clients antenatally, detect complications and make prompt referrals; value cleanliness in their work; promote personal hygiene of their clients; prevent perinatal tetanus; examine the placenta; detect and prevent complications during pregnancy and delivery; and to care for the baby. Additionally they credited training with helping them to change from "bad" things they had formally done; with helping to establish collaboration between the health facilities and the TBAs; and to make early and appropriate referrals. Training has removed the fear they had during delivery; and the fear they had of staff in health facilities.

They claim that training has changed their attitude and the attitude of the community towards them with the result that they have become popular and are called at home night and day.

2.2 Benefits of TBA training to the community were identified in terms of their ability to conduct safer deliveries; provide education on personal and environmental cleanliness and the value of birth spacing; supply contraceptive methods such as the condoms and VFT; and preparation of ORS.

The TBAs claim that there has been a dramatic reduction in maternal and child deaths in their practice since their training and credit this to the training.

3. Beneficial Aspects of the Training.

All groups started off by saying that everything was beneficial. When pressed to identify the most beneficial aspect of the program, the establishment of cordial relationships between TBA and health staff was cited as most beneficial by all groups. The ability to refer, especially early referral for tetanal and advice and at risk mothers; to educate clients and the community on personal and environmental

sanitation, good nutrition, early schooling of children; to advise on family planning and to dispense methods; were among the most frequently cited values.

The support of the revolutionary organs and chiefs in promptly obtaining transportation for emergency referrals was cited as most beneficial by 2 groups.

4. Recommendations in Relation to Training.

All groups thought that the training should be extended (1 group said that 3 weeks was adequate). Other recommendations included: More refresher sessions; monthly seminars; the retention of existing methodology such as songs, demonstration and return demonstrations; the training of all untrained TBAs. 2 groups felt that elderly TBAs need government support.

Other recommendations were that: Written instructions should be provided for community leaders to support the TBAs work in the community; TBAs must be sent outside their training grounds to exchange ideas and learn more from the hospital and other TBAs; TBAs be provided with drugs for the treatment of abdominal pains during pregnancy, gloves, aprons to protect their clothes and torch lights. Finally 2 groups expressed a need for health centre staff to have transportation to ensure regular supervision.

Functioning

5. TBAs indicated that they were doing everything that they were taught in maternal and child health and PHC. They felt that they were better and safer in their practice because of their training.

6. All TBAs claimed that they realized the usefulness of what they had been taught so they have changed their old ways.

After probing TBAs stated that they were not recording referred cases.

Note:- This question could have been too directly challenging. The intent was to see which of their practices they still considered good. Despite the above answer garlic for the treatment of fits was found in TBA kit.

7. TBAs indicated that they were using all the skills they were given.

8. Supervision

TBA's indicated that they liked supervision because the supervisor replenished their supplies, corrected them when they are going wrong and advises on cleanliness. They liked monthly visits. They feel that this is adequate because they have other work to do. They would like the supervisors to have transportation so that they can make visits regularly.

9. Barriers to Effective Functioning.

Some of the major barriers identified which make it hard for TBAs to do their work are: problems with suitable accommodation for delivery; transportation to get to the homes and to get referrals to centers early; adequate remuneration in some communities; problems with record keeping; problems with some clients not accepting referrals; problems with replenishment of items in the kit; no drugs to give to the patient for hemorrhage; shortage of kits for some TBAs. Additionally some TBAs felt that scissors should be put in kits. Older TBAs felt that they needed income generating activities, since they were too old to farm.

10. Relationships and Future.

10.1 In many instances very good relationships were reported to exist between the TBAs and private midwives. Some private midwives become involved in the training. TBAs refer to them and feel free to visit.

10.2 The TBAs all said that the relationships between themselves and the health facilities with which they have been referring were good and supportive, they felt free to go to health posts and rural clinics. However they felt that new staff need to be oriented to them because these staff are not nice to them.

10.3 Communities were seen as mostly supportive particularly the women's fellowship. CDR provides recorders. Some communities were seen as not as supportive because they are not assisting with building a shelter for delivery or ensuring that they get payment due to them.

10.4 If funds to the TBA Secretariat from donors cease; and the government says it has no money, TBAs felt that training and refresher courses can continue if communities are contacted for funds. However they pointed out that communities are being taxed for a lot of development projects like JSS, KVIP etc., so the government should try and fund the program. They nevertheless several suggestions to support continuation were made as follows: TBAs can be self-sponsored; monthly contributions can be made by TBAs and money used to train new TBAs; untrained TBAs could co-operate with trained TBAs; TBAs who have been trained can provide training for other untrained TBAs. Trainees can self-support by feeding themselves; ask untrained TBA to work with trained TBA and if the trained gets c1000 for delivery she will give untrained c500 to assist untrained with financial support for training; trained TBAs can discuss with women's CDRs to help financially from the monies trained TBAs have generated. Additionally to obtain community/Chiefs support-part of TBA's income should be paid to chief and community for future use.

Summary

No. 2

**Focus Group Discussion
Untrained TBAs**

1. Learning Needs.

The major learning needs as stated by untrained TBAs were primarily related to labor and delivery and the care of newborn and infants. Additionally needs were expressed for skills in family planning, nutrition of pregnant women and children and environmental sanitation.

Specifically in the area of labor and delivery they wanted to know more about: Preparation for confinement; delivery of women and the stages of true labor; how to determine or identify true labor; how to identify bad presentations e.g., breech and transverse presentation; how to deliver women in labor efficiently; how to deal with post partum hemorrhage, retained placenta removal and treatment for bleeding; methods of detecting complications and referrals to hospitals or clinic midwives; how nurses go about doing deliveries in the hospitals. Additionally untrained TBAs expressed the need to know more about the scientific aspect of midwifery and hygienic method of conducting labor and how to deliver twins.

For the care of the mother and newborn and infants they expressed the need for knowledge on: care and treatment of both mother and baby after delivery; how to prevent perinatal tetanus; proper way of cutting and dressing of cord to prevent diseases; care of babies born weak and not crying after birth - how to sustain such babies; when to introduce other foods to babies and wean them. Additionally the untrained TBAs felt that they needed drugs to treat unhealthy babies after delivery; a drug to smear around the nipple to stop the baby from sucking so that weaning can start! and knowledge on how to manage diarrhea. It was stated that there are some babies who cry over a long period after delivery and after the cry baby may die, the TBA wants to know why and how to treat or prevent that.

Other needs stated included: how to educate women on family planning; how to educate women on good nutrition for pregnant, nursing mothers and their babies and young children and on weaning diets and how to educate on personal and environmental hygiene. A spiritualist thought some people do not come for prayers early to have spiritual protection, so she wants to know about when to refer.

2. Reason for Wanting to be Trained

Among the major reasons given by untrained TBAs for wanting training was that it would enable them to get legal backing for their work. It was expressed that the training and certification will give the authority to practice without fear.

They also felt that it will help to improve on skills in the detection of abnormalities, miscarriages and care and management of complications, prevent women in labor from fear of delivering at home.

3. Selection Process.

Full support was given to the existing selection process. The untrained TBAs felt that it is good for the community to select one for the training. They were all in agreement with the community's choice. The process used by the community to select TBA's was seen as ideal because those chosen had good knowledge of delivery and perform well. According to those not selected in the first round of training: "Those who were selected performed best. The selection criteria for TBA's for training was based on the character of those selected. Someone who devoted her time for community members (by means of how

they care for post and ante-natal cases), and has patience in performing her work. We don't think they were selected because they were related to the opinion leaders."

Although not chosen, untrained TBAs felt those chosen were eligible and performing to the satisfaction of the community. So the method for selection was good and benefits the whole community.

4. Support Required.

The Untrained TBAs felt that the supportive things which will make it easier for them to provide service to their communities included: Provision of rooms for delivery. (They felt it will be more appropriate if relatives of the pregnant women brought them to a more central place viz: delivery rooms built by the community); remuneration for TBAs in the form of money. (This must be determined by the authorities of the programme because it will be more acceptable to our communities that way); promises by community members to farm for TBA's to be enforced; community support of feeding, travelling cost etc. for training; help to weed farm and provide uniform to wear when working; devotion of time on the part of trained TBAs; training to all TBAs; drug supplies to treat the cord; Provision of financial support to help hire a car for referral cases; provision of drugs for all emergencies.

5. Best Time for Training.

May and August were given as the best months for training, so as not to coincide with farming activities and the peak fishing season - in August. Some of those in farming areas felt that they could attend training anytime if the community would assist with weeding their gardens.

Length of Training

All felt they are prepared to train for as long as one to two months.

Summary

No. 3

Focus Group Discussion Opinion Leaders

This summary is a composite of the input of 5 focus groups of opinion leaders. Taken singly these groups showed different levels of involvement and commitment to the work of the TBAs in their area. Although this distinction may not be as evident in a summary, it suffices to show what is and can be done by communities in support of the TBA.

3.1 What TBAs Should be Doing in the Community.

Opinion leaders felt that since the distance from the villages to the nearest health facility was far, the TBA should do the following: Attend to the delivery of women in labor; educate the people on personal and environmental hygiene; perform A.N.C. in the community; find out all pregnant women and educate them to attend AN Clinic for care and Tetanal; care cord in such a way to prevent infection; refer all cases above her knowledge to the midwife's clinic or hospital; teach the community on family planning; and educate mothers on care of their children.

When the opinion leaders were asked if the TBAs are performing these tasks, they responded in the affirmative. According to opinion leaders: whereas previously women had to travel far to deliver they now expect delivery locally; women are now protected against Tetanus infection through encouragement of Trained TBAs and now children hardly die from infantile tetany; stillbirths are now not heard of; and immunizations now protect children against the 6 killer diseases. Additionally mothers are no longer afraid of going to hospital for ANC care, TBA's educate them on its importance and encourage them to go for ANC from 5 months of pregnancy onwards; when women have difficulty during pregnancy they are advised by the TBA to use family planning. TBA's themselves accompany mothers and children to the hospitals. This has broken fear of hospitals by mothers. In some villages the TBA gets the women together to educate them on family planning.

The Opinion Leaders felt that TBA's are respected at some hospitals thus mothers receive prompt attention. They felt that the number of TBA's being trained are too few to meet the needs of the communities. More TBA's should be trained.

3.2 How Community Can Support TBA.

Possible and ongoing support for TBAs was identified under 5 main categories; housing for deliveries; assistance with farming; obtaining of clients and payment; support with transportation; support in ensuring that TBA could conduct health education.

The current involvement in the above varied by community.

In relation to housing, some communities had already built separate places to service the communities; others indicated that they were in the process of doing this. Some communities had undertaken to repair the house of the current TBA, or add a room to her house so that she could conduct deliveries undisturbed. One community had gone as far as purchasing materials, but had to switch it to a school building. This group felt that they were being asked to do too many things at once as a poor community and that if they could be given the materials they would provide the labor.

The reason for wanting a building varied. In one community it was expressed that the TBA was called to attend to clients in their homes. In some cases she is carried on a bicycle to villages nearby. This was

rather tiring taking her age into consideration, so they felt if an accommodation is provided, it will help her and reduce the stresses of having to walk miles to attend to clients. In another community they simply did not like where the TBA was doing her deliveries in her home because of lack of privacy and the state of her facilities. In yet another the feeling was that it was more convenient for the woman to be observed in a separate building for a couple of days before returning home. It was easier for the family to look after the mother in this facility than in the TBAs house.

In relation to support with farming, communities felt that this was necessary although all communities did not seem to be doing it. Feelings were expressed that since the TBA is not paid by either the government or the community, another means of supporting her was periodically going to help weed her farm. Others felt it was their responsibility to provide her with a decent farm every season.

The question of payment for the TBA was raised by every group. Some groups had set a standard fee and were assisting the TBA to collect this. In another community the fee was set and the TBA was required to contribute to the community chest a certain amount which was used to replenish the kits from time to time. One community had stipulated that they had planned to help with items such as soap, kerosene, and furnishings for the delivery facility. A novel approach taken by one community was to fine any woman who had gone to an untrained TBA 10,000 cedis, and use the money to purchase drugs etc., for the community! Anyone who does not pay TBA is "dealt with". Hence, TBAs are promptly paid in this community. One community stated that since the TBA will not be effective without clients, another support was for all the males to encourage their wives to go to her for care.

Communities stated that they were assisting the TBA to find transportation in emergencies. Finally one Community set aside every friday for Health Education forum for all community members with TBA's and other health related agents. And made it compulsory for all to attend as they do not go to the farm on this day.

The need for regular meeting of community members with TBAs to enable them to hear the views of the people and the grievances of TBAs and institute corrective measures was identified by one group.

3.3 Any Changes Needed

There was consensus among opinion leaders that they were happy with what had taken place so far. The only change they wanted in their situation was to have a second TBA trained. If any changes are seen as necessary by the program managers, however, the Community would support that because the program is respectful of community members.

No need was seen for a change in the selection criteria.

As to a change of site for training, some groups felt since the TBA had not complained it meant the training site was alright and need not be changed. On the other hand, if the authorities wanted to do that for any reason, the Opinion Leaders will mobilize their resources to support the TBA to go there. Two groups felt that the nearest health facility was the best site for the training since it exposes the TBA to health workers and facilities.

Opinion Leaders felt the monthly supervision was quite good since it will help both the TBA and the trainer to change any practices which is out of the way. "At times the trainer comes to meet the TBA delivering a client and does on the job training which is quite good" said a respondent. There is the need for constant in-service training. "She is doing quite well but may need to know current changes in delivery, family planning and care of women and children."

As to who should train TBAs, there was general agreement that the trainers who trained the previous TBAs should be allowed to train TBAs since from the Opinion Leaders observation they are friendly and respectful to all the community members.

In relation to preparation of TBAs, Opinion Leaders indicated that they had assumed and will continue to assume responsibility for all expenses related to the training of the TBAs. Additionally TBA's are exempted from communal labor during their training.

In some Communities the community assembles on Friday to be given feed-back on training by TBA. The community leaders are informed by supervisors of their visit and they in turn inform TBA and all community members. If the community does not understand something that the TBA says the nurse is made to clarify the issue during supervision

Additionally it was said that: TBAs should be registered and a certain amount set aside as payment for TBAs; TBAs trained in the community should be made known to the people; Medical personnel should invite all 16 electoral areas and 27 units plus TBAs, chiefs and sub-chiefs to establish a platform for negotiations.

In support of what is now taking place, the opinion leaders at one village pointed out that: Mothers are now enjoying very safe deliveries without the previous hassle of running helter skelter to find vehicles in the night or odd times of the day to convey women to the hospital. These days, you only see women with new babies on their backs and when you enquire as to when the birth took place or where the child was delivered, they only tell you happily about the date and mention the Trained TBA. The eating habits of their women have greatly changed for the better. Hence they see well nourished women and children. They felt that general development has now come to their country. This sentiment was shared by another group who commented on the improved health and care of their women and pointed out that in the last month, 8 mothers delivered, and they now have 8 healthy mothers and 8 healthy babies.

4. TBA Involvement in Family Planning.

All groups agreed that the TBA should be involved in family planning. Supporting reasons varied and seemed to be reflective of current TBA involvement and skill. Most communities did not seem to feel that the TBA was as yet fully prepared for this activity. Example: "Due to the fact that we reproduce too many children and there is no spacing, we have problem caring for the children, so we feel if TBAs should give family planning services. It will be desirable and appreciated." When asked if they felt the TBAs will be able to educate and give family planning services, they said yes they can if taught. Another group said that it was right to involve TBAs in Family planning because "if we had known of FP and had the service we would not have had so many children which we are at the moment having difficulty in caring for. So we feel it is very appropriate to involve her." At the moment she educates us on the importance of spacing and for those who have too many to stop having anymore children to prevent complication during labor. Again they felt that although they heard of family planning on radio, it is not helpful because they cannot ask questions. But if they hear it from the TBA, they are able to ask questions. To those questions which she cannot answer she goes to trainer for the correct answers and it is quite helpful.

When asked if they felt that their TBA could learn and extend the knowledge to them, they responded in the affirmative. They said since she has been trained to do delivery without problems, they know she will be able to give family planning services if taught.

It was said that TBA's should be the ones to deliver F/P services because they always have close relationship with the mothers they attend to and they can convince them better as to the need and importance of F/P. It was felt that TBAs are the closest to the community, therefore, the community members would appreciate and understand them better and quicker than an outsider; and that

TBAs have more time to spend in the community than a health worker who comes and leaves. One solution to the FP problem was to increase the number of TBAs and F/P services to aid the government's efforts. This it was said would enable every TBA to receive F/P advice and service. It would save the government the mobile and T&T charges by health workers.

Additionally it was felt that the TBAs know those within the community with high parity or large families. A TBA would therefore be able to go directly to this couple between the hours of 6pm - 8pm when the family would be relaxing and available in the house to counsel and advise them. Not so the health worker who would not know the real F/P targets or get to them at that hour. If the TBAs are given this added responsibility and every support and backing, they would take their responsibility very seriously and perform the service better. This is because she has established good rapport and relationship with community members. The hospital workers do not know the communities or their norms.

One group felt that the economics of the whole F/P service should be critically analyzed because community members would not spend money to be travelling to buy F/P devices/services or F/P message. Since the Government is now talking about Grassroots Democracy so the TBAs at the grassroots should be made to render this service. Therefore, more TBAs should be trained to ensure that all communities get F/P service.

5. How to Increase Family Planning Usage.

Opinion Leaders suggested that usage of FP services in the community can be increased if: Regular FP education e.g., once a month or once a week is done within communities; more posters on FP are placed at vantage points within community; organized video shows on FP followed by discussions and question time are held; churches are encouraged to spread FP message so that people would know the government is serious.

It was felt that FP posters should not be limited to hospitals and health facilities only, as posters talk to them a lot and re-enforce knowledge on FP. Example was cited of posters that have made them aware of shortages of food, facilities and utilities as being a contributory factor of population explosion.

The need to train TBA's in FP service delivery was stressed by 2 groups. This is because the community understands the TBAs better. An example given by one group was as follows: FP Personnel had a rally for the community; women were allowed to speak out their problems, men also spoke out. After a lot of discussion the community was so convinced that FP is good therefore a lot of condoms were purchased. They felt therefore that regular meetings should be held for discussion (3 monthly); both men and women should be guided in the use of the various methods; educational materials - entertainment; correct FP education should be organized to help both men and women to exercise FP. Publicity Vans should be used to herald group meetings instead of gong-gong.

All groups expressed gratitude for the visit and the opportunity to make their input into the progress of the program. The government in helping TBAs receive their payment from mothers after delivery.

Summary

No. 4

Focus Group Discussions Women of Childbearing Age/TBA Clients

4.1 Choice of Place for Delivery.

The general response was that these women went either to the TBAs house or she came to theirs. Communities were now encouraging them to use the trained rather than the untrained TBAs. Both groups indicated that they based their choice on the fact that they had used the TBA before training and that she was very efficient

When asked about Choice of Service - Government or TBA?

Of the 18 women, only one had not been delivered by a TBA, but she said she will go to the TBA for assistance when she delivers again. They all said that they prefer to be delivered by the TBA.

4.2 Pre Vs. Post Training Difference.

Of the 18 women in the focus groups, 17 had used the TBA's services before and eight (8) had used the services before and after training. They all observed differences in services given before and after training. They indicated that before training: TBAs were not giving ANC or visiting clients after delivery; they were not caring for the cord of the baby and even used the client's own clothing irrespective of their cleanliness; laboring women squatted to deliver; they did not allow clients to eat anything during labor and did not give antenatal care. After training the TBAs were doing all of the above and uses their own kits and mackintoshes (rubber) and cleans them herself. She also uses cord ligature, clean cotton wool to dress the cord with shea-butter and salt. Trained TBAs give care for a week.

4.3 Differences Between Trained and Untrained TBAs

The response to this question revealed that clients perceive differences between the trained and the untrained TBAs. The trained TBAs are said to have patience and deliver the baby gradually; to use clean mackintosh. clean cotton wool to clean the baby's eyes and cord and use ligatures. They use salt in shea-butter to dress the cord until it falls off; visits the mother and baby for one week; and they refer promptly for complications;and women in labor lie on their back. laboring women are given light food.

Untrained TBAs and TBAs before training were said not to have done any of the above and the woman squats during delivery.

4.4 Any Changes?

According to clients:

The TBA has no privacy. All the deliveries are done either in her own room or in the clients room. If she is provided with accommodation then she can have the required privacy and will perform better.

TBAs lack drugs. If one is in labor, she has no drug to give to her client. When you visit the hospital drugs are given to patients and even drops of drugs are given to the babies. The TBA could perform better if she is given drugs for her patients.

Table B

Content of TBA Kits

CONTENTS	1		2		3		4		5		6		7		8		9	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Total Number seen	10		8		4		12		6		6		1	100	47			
TBA Record Book	10	100	7	88	3	75	12	100	6	100	6	100	1	100	45	96		
FP Record Book	-	-	-	-	-	-	12	100	-	-	-	-	-	-	12	26		
Mackintosh	9	90	4	50	4	100	12	100	6	100	6	100	1		42	89		
Towel for Handwashing	10	100	7	88	3	75	12	100	6	100	6	100	1		45	96		
Sponge for Handwashing	10	100	2	25	4	100	11	83	6	100	6	100	1		40	85		
Soap and Soapdish	10	100	6	75	4	100	12	100	6	100	6	100	1		45	96		
Cotton wool	10	100	7	88	4	100	12	100	6	100	6	100	1		46	98		
Condoms	8	80	2	25	4	100	12	100	6	100	5	83	1		38	81		
Foaming Tablets	5	50	4	50	2	50	11	92	3	50	5	83	1		31	66		
Blades	9	90	5	63	4	100	12	100	6	100	6	100	1		43	91		
ORS	1	10	4	50	2	50	12	100	6	100	4	67	-	-	29	62		
Referral Cards - Blue	10	100	8	100	3	75	12	100	6	100	6	100	1		46	98		
Referral Cards - Red	10	100	8	100	3	75	12	100	6	100	5	83	1		46	98		
2 Bowls	10	100	8	100	4	100	12	100	6	100	6	100	1		47	100		
Teaspoon	3	30	-	-	2	50	8	75	1	17	2	33	-	-	16	34		
Boiled Water for Eyes	3	30	2	25	2	50	6	50	6	100	3	50	-	-	22	47		
Cord Ligature in Spout	6	60	4	50	3	75	11	92	6	100	4	69	1		35	74		
Gentian Violet	6	60	1	13	3	75	-	-	6	100	6	100	-	-	22	47		
Cord Spiret	9	90	4	50	3	75	12	100	5	83	6	100	1		40	85		

B-11

CONTENTS	1		2		3		4		5		6		7		8		9	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Disinfectant	6	60	-	-	2	50	2	17	-	-	2	33	1	-	13	28	-	-
Copper Sulphate	1	10	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Mercurochrome	-	-	1	13	-	-	-	-	-	-	-	-	-	-	1	2	-	-
Salt	1	10	-	-	-	-	4	33	-	-	-	-	-	-	1	2	-	-
Sugar	1	10	-	-	1	25	4	33	1	17	-	-	-	-	1	2	-	-
Shea butter	-	-	1	13	-	-	1	8	-	-	-	-	-	-	-	-	-	-
Garlic for Convulsions	1	10	-	-	-	-	-	-	-	-	-	-	-	-	2	4	-	-
Palm Kernel Oil	1	10	-	-	-	-	-	-	-	-	-	-	-	-	1	2	-	-
Demo Penis	1	10	-	-	-	-	-	-	-	-	-	-	-	-	1	2	-	-
Per	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	2	-	-
Scissors	-	-	-	-	-	-	-	-	-	-	2	33	-	-	2	4	-	-
Stones for counting	-	-	-	-	1	25	-	-	-	-	-	-	1	-	1	2	-	-

1. Mfantsiman
2. Gomoa Oguaa
3. Techiman
4. Badu-Wenchi
5. Tanaso
6. Yawsae
7. Winneba

Total - All sites combined

Appendix C

Training

NTBA Job Analysis

Competency-Based Learning Model

Skills Checklist - Learning Objectives

Mastery Learning Plan

NTBA Job Analysis

What is it?

A job analysis (often called a task analysis) is a process of breaking down the responsibilities of a health worker's job to determine, in specific terms, what s/he must do in her/his role to deliver essential health services.

This example of job analysis for the NTBA and MOH trainers and TBAs is broken down to the level of task, competencies and skills. Knowledge and attitudes for each skill could also be identified, but were not included in this example due to time constraints. The Training Evaluator established the seven (VII) priority job tasks which were analyzed here.

Tasks related to the development of the NTBA Program.

- I. Plan, Develop, Implement, Manage, Monitor and Evaluate Training
- II. Analyze, Plan and Provide Management Support
- III. Promote Health and Provide Ante-natal Services
- IV. Provide Safe Interpartum Care During Labor and Delivery
- V. Provide Post-natal Care During the Lying in Period (1st 8 days)
- VI. Promote Health and Provide Family Planning Services
- VII. Promote Health and Provide Primary Health Care Services

Job analysis process:

The job analysis process went through the following steps.

1. The job of the TBA was first analyzed for use to evaluate TBA performance and impact of the Program.
2. The job of the Master Trainer was next analyzed against the objectives and content of the TOT Manual and TBA Training Manuals, Vol. I-III.
3. The job competencies for a Master Trainer, and those which would be relevant to NTBA facilitators, Regional Contact Persons, TBA Trainers/Supervisors and TBAs were then reviewed with all of these categories of workers except the TBAs (this was done by the clinical specialist who work primarily with TBAs).
4. Based on feedback during process step (3), the job analysis was converted into a "generic list" of task, competencies and skills, again using the content of the TOT Manual and TBA Training Manuals, Vol. I-III, with special attention being given to the job of the TBA Trainer and TBAs.
5. The final step in the process would be for NTBA facilitators, Contact Persons, Master Trainers, Trainers and appropriate persons from other MOH Divisions, to convert the generic job analysis into an analysis specific to the job of a:
 - A. NTBA Facilitator
 - B. Regional Contact Person
 - C. Master Trainer
 - D. TBA Trainer/Supervisor
 - E. TBA

6. Each analysis would then be reviewed with a representative sample of workers for each category. Job performance could be analyzed, training needs assessed, and revisions in the job analysis completed.

Using the "Generic Job Analysis":

The columns down the right hand side of the page are coded as follows.

NTBA = NTBA Facilitator
RCP = Regional Contact Person
MT = Master Trainer
TOT = TBA Trainer/Supervisor
TBA = Traditional Birth Attendant

+ = Part of the job
- = Not part of the job
+/- = Undecided if part of the job

The "undecided" category caused NTBA Facilitators, Contact Persons, and Master Trainers the most difficulty in analyzing task VI: Promote Health, and Family Planning Services. This was because at one time all were trained to provide the services listed under the task, but few are actually provided these services any more due to their roles and responsibilities as Trainers and Administrators.

NTBA Job Analysis

TASK I: Plan, develop, implement, manage, monitor and evaluate training		NTBA	RCP	MT	TOT	TBA
Competency 1. Provide strong leadership and develop high performance teams	1	+	+	+	+	+
Skill 1.1 Explain the goal and objectives of the NTBA program	1.1	+	+	+	+	+
Skill 1.2 Describe the MCH/FP situation in Ghana and the role of the TBA as defined by the MOH	1.2	+	+	+	+	+
Skill 1.3 Use the team performance model to strengthen teams	1.3	+	+	+	+	+
Skill 1.4 Promote and maintain interest of workers and community in TBA activities	1.4	+	+	+	+	+
Competency 2. Assess community health needs	2	+	+	+	+	+
Skill 2.1 Orient community leaders and members to program	2.1	-	-	+	+	-
Skill 2.2 Build trust by getting to know the community	2.2	-	-	+	+	-
Skill 2.3 Clarify goals/roles and plan community health needs assessment with leaders	2.3	-	-	+	+	-
Skill 2.4 Gain commitment from community members to participate	2.4	-	-	+	+	-
Skill 2.5 Design, implement, test and revise assessment instrument	2.5	+	+	+	+	-
Skill 2.6 Assess (including beliefs and practices) analyze, interpret needs against available health statistics	2.6	+	+	+	+	+
Skill 2.7 Prioritize needs considering community willingness, ability, interest and available management support systems	2.7	+	+	+	+	+

		NTBA	RCP	MT	TOT	
Skill 2.8	Plan with community how best to meet needs and implement appropriate strategies for meeting needs	2.8	-	-	+	+
Skill 2.9	Work with community to assess if needs were met	2.9	+	+	+	+
Competency 3.	Analyze job(s)	3.	+	+	+	+
Skill 3.1	Assess the job tasks	3.1	+	+	+	+
Skill 3.2	Analyze competencies for each task	3.2	+	+	+	+
Skill 3.3	Analyze skills for each competency	3.3	+	+	+	+
Skill 3.4	Submit analysis for expert review and revision	3.4	+	+	+	+
Competency 4.	Assess learning needs	4.	+	+	+	+
Skill 4.1	Plan learning needs assessment	4.1	+	+	+	+
Skill 4.2	Design, test and revise assessment instrument (skill check-lists)	4.2	+	+	+	+
Skill 4.3	Establish criteria for worker selection for assessment and intervention	4.3	+	+	+	+
Skill 4.4	Assess, analyze, interpret needs	4.4	+	+	+	+
Skill 4.5	Decide on appropriate intervention: policy, training, management, other	4.5	+	+	+	+
Skill 4.6	Prioritize needs considering worker willingness, ability, interest and available management support systems	4.6	+	+	+	+
Skill 4.7	Plan and implement appropriate strategies for meeting needs	4.7	+	+	+	+
NOTE: If a training strategy, continue with next competency, if a non-training strategy, go to Competency <u>9</u> , Monitor and evaluation						

91

		NTBA	RCP	MT	TO	
Competency 5. Plan training						
Skill 5.1	Create a vision for meeting training/learning needs	5.1	+	+	+	+
Skill 5.2	Explain and follow the competency-based learning model (Appendix __)	5.2	+	+	+	+
Skill 5.3	Organize competencies into learning paths	5.3	+	+	+	+
Skill 5.4	Cluster and sequence skills for mastery	5.4	+	+	+	+
Skill 5.5	Draft, submit for approval and finalize training plan	5.5	+	+	+	+
Competency 6. Establish training management support system (see Task II)		6.	+	+	+	+
Competency 7. Develop the learning program and materials		7.	+	+/-	+	+
Skill 7.1	Plan and document the materials development process to follow: 1) Decide on structure for materials 2) Design learning path to competency 3) List sessions for basic competency and mastery 4) Collect resource material 5) Write and organize content 6) Check content with experts 7) Pre-test and finalize materials	7.1	+	+/-	+	+
Skill 7.2	Decide on the types of materials to be developed (TOT, TBA training)	7.2	+	+/-	+	-
Skill 7.3	Decide on training materials packaging, format and design at the: - glance layer, - skim layer, and - body	7.3	+	+/-	+	-

			NTBA	RCP	MT
Skill 7.4	Prepare purpose and story (or song, poem, skit) for each competency to motivate learning	7.4	+	+/-	+
Skill 7.5	Write learning objectives which are observable and measurable following the criteria in a skill checklist	7.5	+	+/-	+
Skill 7.6	Group skill objectives for basic competency and for extended practice for mastery*	7.6	+	+/-	+
* Note: Basic competency is when the learner has reached a level of supervised competency following demonstration, practice and return demonstration or other structured learning (peer learning; structured application) when they can start practicing a skill for mastery with minimal supervision.					
Skill 7.7	Develop learner evaluation criteria and instruments, which measure if learning objectives were met and are: - significant, - valid, - reliable, and - feasible.	7.7	+	+/-	+
Skill 7.8	Prepare learning activities to develop basic competency	7.8	+	+/-	+
Skill 7.9	Prepare learning activities to practice for mastery	7.9	+	+/-	+
Skill 7.10	Write student text technical content if appropriate resource materials are not available	7.10	+	-	+
Skill 7.11	Develop instructions and resource materials for trainer	7.11	+	-	+
Skill 7.12	Develop and follow a template (example) for organizing teaching/learning session/lesson plans into a consistent presentation design	7.12	+	-	+

- 82

		NTBA	RCP	MT	TOT
Competency 8 Implement Training	8.	+	+/-	+	+
Skill 8.1 Develop and follow action plan for implementing training (see TOT Manual, page 79-81)	8.1	+	-	+	+
Skill 8.2 Develop guidelines and instruments for pretesting materials	8.2	+	-	+	-
Skill 8.3 Orient trainers to pretesting materials	8.3	+	-	+	+
Skill 8.4 Pretest materials with target learners	8.4	+	+	+	+
Skill 8.5 Collect, analyze and interpret data from pretest	8.5	+	+	+	+
Skill 8.6 Use findings from pretest to revise materials	8.6	+	-	+	+
Skill 8.7 Distribute and train other trainers (following the competency-based learning model) to implement a competency-based training/learning system	8.7	+	-	+	+
Competency 9 Monitor and Evaluate Training	9.	+	+	+	+
Skill 9.1 Review, and adapt if necessary, a seven step systematic process for program monitoring and evaluation:	9.1	+	-	+	-
1) State questions, then generate, select, and adopt indicators for program progress.					
2) Identify data sources and data collection methods.					
3) Prepare data collection instruments.					
4) Determine the sample.					
5) Prepare the evaluation management plan and schedule.					
6) Collect, analyze and interpret data results.					
7) Use findings for decision making.					

		NTBA	RCP	MT	TOT	
Skill 9.2	Train Master Trainers in how to develop and use program monitoring and evaluation indicators which are: - significant, - valid, - reliable, and - feasible.	9.2	+	-	-	-
Skill 9.3	Train TBA trainers how to use indicators and data collection instruments	9.3	-	-	+	-
Skill 9.4	Collect, analyze and interpret data results.	9.4	+	+	+	+
Skill 9.5	Use results to monitor, evaluate, to make decisions and take action about training	9.5	+	+/-	+	+
Skill 9.6	Report results, decisions and revisions in action plan to NTBA and MOH	9.6	+	+	+	+

NOTE: THE EXTENSIVE JOB ANALYSIS WAS NOT A REQUIRED PART OF THE TRAINING EVALUATOR'S SOW. IT WAS DEVELOPED TO PROVIDE A SOLID TECHNICAL BASE FOR THE FUTURE PROGRAM. THE COMPLETED PART OF THE ANALYSIS ENDS ON PAGE 8, SESSION VIII-B, GROWTH MONITORING, TBA MANI VOL. III.

THE COMPLETED SECTIONS ARE ADEQUATE TO ILLUSTRATE THE JOB ANALYSIS PROCESS, AND FOR USE IN EVALUATING TRAINING PROCESS, MATERIAL AND METHODOLOGY. DUE TO TIME CONSTRAINTS, THE TRAINING EVALUATOR WAS NOT ABLE TO COMPLETE THE REMAINDER OF THE JOB ANALYSIS FOR:

- growth monitoring
- diarrhea and ORT/SSS
- immunizations
- clean home and environment

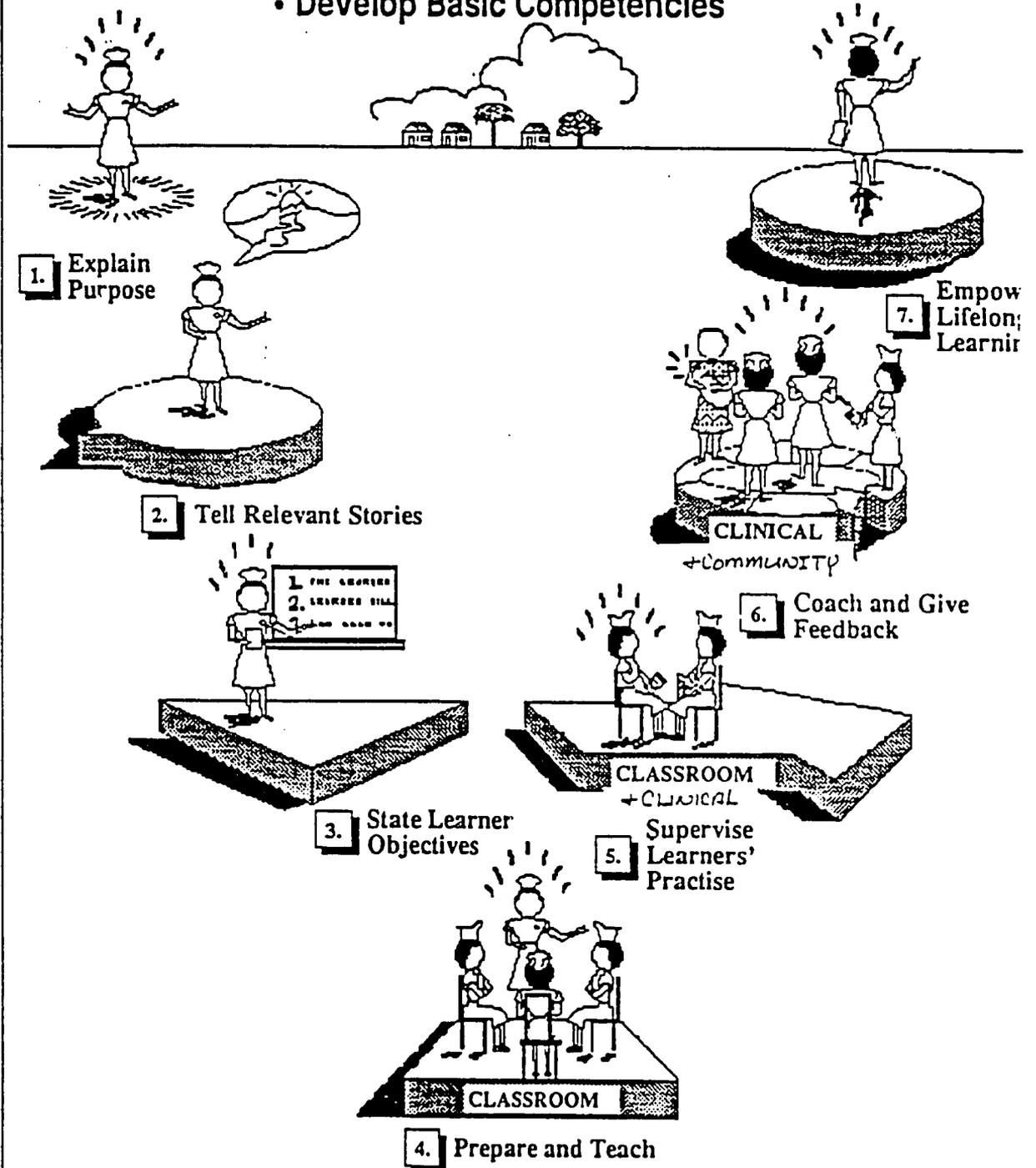
85

The Competency-based Learning Model

• Motivate Learning

• Practise for Mastery

• Develop Basic Competencies



Essential Knowledge Skills and Attitudes

SKILLS CHECKLIST

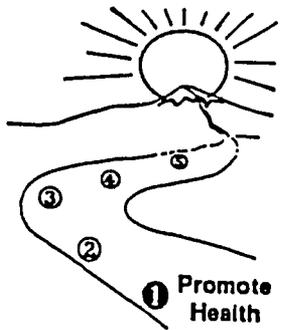
Writing Learning Objectives

Use this *skills checklist* as a guide when writing learning objectives and to evaluate your learner centered learning objectives.

Rating: 1 = Needs Improvement
2 = Satisfactory

STEPS	RATE	COMMENTS
The Learning Objective:		
1. Clearly specifies what the learner should do.		
2. States an observable action.		
3. States an action which is measurable.		
4. Specifies the important conditions under which it should be performed.		
5. Specifies the necessary equipment or materials.		
6. Specifies the minimal acceptable level of performance.		
7. Is relevant to PHC competencies.		
8. Can be achieved within the time and with the equipment indicated.		
9. Is logical and has internal consistency.		

Note: Each step must receive a rating of 2 for the entire learning objective to be rated as *satisfactory*. Comments should illustrate how to correct any part of the objective receiving a rating of 1.



Competency Overview

Competency 1:

Skill 1.1

Skill 1.2

Learning Objectives

To attain mastery, the learner will be able to:



Required Clinical Experiences

The following is a list of required mastery practise experiences that you will have to accomplish:



Other Learning Activities

Assessment

You will be assessed in the following manner:



Task

Competency

Appendix D

Management

**Indicators for Management and Monitoring
of Future NTBA Program Development**

Scope of Work of ACNM

NTBA Program Action Plan

Indicators for Management and Monitoring of Future NTBA Program Development

The following have been developed as key indicators to guide the ACNM/NTBA Program monitoring. Program managers from ACNM, NTBA and USAID can review these and use them to assure the direction and measure the progress of the ACNM/NTBA Program.

- Clear ACNM/NTBA program plan for entire program five year time frame
 - Organizational chart with defined program internal structure and defined relationships with other organizations
 - Clearly defined position descriptions for acnm program director, staff and overall scopes of work for major technical assistance areas. Same for ntba staff and local program technical assistance. Outline of time requirements, tentative schedules and performance to date.
 - Clear annual program plans of action
- Annual evaluation plan and process defined. Results of evaluations to date.
- Budget projections statement developed (overall and annual) and linked to program accomplishments and activities.
 - Defined plan for, and documentation of, the development of support systems, HIS, communication, referral training and supervision, etc.
 - Definition of clinical review process, method to incorporate changes into ongoing program.

Scope of Work of ACNM

While the Mission did not specifically request the team prepare a scope of work for ACNM based on our findings, the Evaluation teams believes this to be a valuable input into the planning for the future Program. The American College of Nurse Midwives will provide technical assistance to NTBA to build a lasting NTBA/MOH institutional capability for planning, management, monitoring and evaluation of TBA activities.

The Scope of Work of the Project Director will include the oversight of all Program systems and activities. Since ACNM TBA Program staff is small, the Director will also have major direct responsibility to provide TA in the development of NTBA management systems and training program development. Consistent short term international TA will be used to supplement ACNMs TA support to the Program. It is anticipated that ACNM will partner with a qualified local TA firm to ensure TA continuity to NTBA.

Both the ACNM Project Director and short term TA will be responsible to promote the institutionalization of NTBA staff capability and systems. This will include training NTBA staff to actively define and develop management systems for the support of the NTBA, to develop and strengthen competency based training programs and materials development process in addition to strengthening the clinical content of training especially in the area of family planning.

The Evaluation Team outlined a Program Action Plan for year one.

The development of the full five year Program can be developed when a further assessment of the NTBA and CMOH staff institutional absorptive capabilities has been done.

Specifically ACNM provide support in the following areas:

Management Systems Development

Assist NTBA to define and develop the following effective NTBA management systems: personnel, program design, management and monitoring, health information systems, supplies and medical equipment, communication, finance, referral and others.

Specifically:

Assist NTBA to develop a Program plan and annual plans for all program activities to effectively integrate all training, systems development and monitoring activities.

Through NTBA, strengthen the MOH TBA capability and activities to plan, manage and evaluate TBA training and support for the training of TBAs in USAID supported regions. Systems and methodologies developed as part of this Program can be shared with other MOH regions.

Review and revise the clinical and communications component to strengthen curriculum, training materials and processes, especially in the area of family planning for NTBA staff, core MOH TBA trainer and TBAs.

Assist NTBA to define plan and establish indicators and time lines for Program systems and activities for NTBA and for the institutionalization of NTBA activities within the MOH at the end of the Program.

Assist NTBA to implement an effective internal annual evaluation of all Program and administration components against indicators established as part of the Program plan.

Training and Materials Development

Assist NTBA core staff to define, write and implement a training component plan for the planning, management, monitoring and evaluation of all NTBA training and materials development using a competency based methodology.

Specifically:

* Assist NTBA to develop, document and follow a systematic process for training development at the programmatic level.

Assist NTBA program staff and MOH Mts to develop a core capability to plan, develop, implement, manage, monitor and evaluate competency-based teaching/learning methodology and materials.

Assist NTBA to strengthen existing Master Trainers' and TBA trainers'/supervisors' teaching, management and supervision skills to the level of mastery through in-service training, based on preassessed learning needs.

Assist NTBA to write and use performance indicators for program monitoring and evaluation.

Assist NTBA to develop, promote and implement a plan to institutionalize training, and a core of trainers, within the MOH which is affordable and sustainable

Assist the NTBA to plan, implement and evaluate and assure the training of an additional 3000 TBAs in USAID supported NTBA Program regions. Also assure the supervisory retraining of TBAs and MOH staff trained in the previous NTBA Program.

N.B. further specifics on the ACNM scope of work can be adapted/upgraded from those detailed in the NTBA column of the Job Analysis table in Appendix B

Clinical Area

Analyze, review and develop clinical component of NTBA Program jointly with NTBA and MOH to assure accuracy of clinical information and appropriateness of clinical content and approach.

Assist NTBA to develop and test a systematic process for introduction of new clinical content into the NTBA Program, i.e., correct and appropriate training, norms, supervision, and other support systems for introduction of TBA distribution of oral contraceptives, iron tablet, etc.

Jointly with NTBA and MOH conduct an annual review of clinical content of Program to assure accuracy and appropriateness of NTBA Program.

Assist NTBA to develop and strengthen the clinical and motivational component of the family planning training and supervision of NTBA.

NTBA Program Action Plan

The future NTBA Program plan should be developed in an intensive joint ACNM, NTBA, MOH planning effort in the initial month of the Program to provide a overall blueprint for the comprehensive five year Program. This Program Plan should define the NTBA's approach to the development of the management, training and clinical components and indicate their integration.

The Evaluation Team was able to develop a Program Action Plan for the first year of the future NTBA Program. The full five year Program can be developed with the assessment of the NTBA and Core MOH staff institutional absorptive capabilities. It is expected that the findings and recommendations of the final report of the previous Program will be incorporated into the Plan for the future Program.

The future NTBA Program is to begin in July 1992. This interim period is an excellent opportunity for ACNM, NTBA and the MOH to Program review their Program internally and begin the process of planning and preparing for the new Program. This will require intensive preparation for the July planning session on the part of all parties.

It is anticipated that ACNM will partner with a local TA firm to increase TA continuity to NTBA. It may be possible to include this group in the initial planning sessions if a decision is made before the initiation of the Program.

Management Systems Development and Implementation

Development of the management systems will require intensive TA from ACNM staff and other TA advisors working with NTBA. Additional training in management systems may be included with short term training courses for NTBA and key MOH staff.

It is anticipated that the ACNM Program Director will oversee all TA and will consistently provide management TA to the Program. S/he will develop SOWs for short term management systems TA and monitor progress. Consistent high quality TA is crucial to the success of this component.

NTBA Training Plan

The NTBA Program training action plan will be one component of the overall NTBA Program Plan and will be sequenced within the overall program planning and management development activities.

The following are activities within the training component of the NTBA overall Program. The following draft Action Plan includes the first year's activities for the training component development. Four to six months of consistent international training and materials development TA is needed for the initial year. It is expected that both the training and materials development responsibilities in the SOW can be done by one advisor to promote continuity. The ST international training and materials development TA will draft the SOWs for the local TA. ACNM will oversee and approve the final SOW and hire the local TA.

Activities.....

First six weeks international management TA is planned for month one

First six weeks international training TA is planned for mid month third month

Review evaluation recommendations and develop comprehensive Program plan (NTBA/MOH/ACNM)

Update assessment of NTBA and MOH program situation

Develop plan for systems development for HIS, referral, communications, etc. Establish sentinel indicators for measurement of progress during implementation

Establish practical protocols and system for consistent communications and support between NTBA and ACNM.

Conduct joint review and revision of Program budget

Discuss and define Program wide TA needs and outline draft SOWs for joint and USAID review

Discuss and promote plan to institutionalize NTBA within MOH (NTBA/MOH/ACNM/USAID)

Plan and write indicators and monitor program (NTBA/MOH/ACNM/TA)

Establish the Plan for the systematic process for training development at the programmatic level (NTBA/MOH/ACNM)

Complete second draft of job analysis for 5 categories of workers,

Develop instruments, assess community and learning needs of trainers/supervisors (NTBA/MOH/ACNM)

Evaluate program progress against indicators every six months (NTBA/MOH/ACNM/USAID)

Develop sow for local TA for management and training, interview and make recommendations to ACNM and USAID.

The above can be addressed in an initial six week international consultancy

Second six weeks international training TA for materials development and training at mid eighth month

Plan training to meet needs

Develop competency-based teaching/learning materials, skills checklists, Supervisor's Site Visit Booklet to meet learning needs into:

- a. develop basic competency
- b. practice for mastery

complete 3rd draft of job analysis (after step 7) (NTBA/MOH/ACNM)

Third six weeks international training TA will take place at the 12th month

Implement Training:

Core Group

Pairs of trained and untrained Mts

Pairs of trained and untrained TBA trainers/supervisors

The following activities will be assisted by local TA in the months following the third international visit

Pairs of trained and untrained TBAs trained

Evaluation step and levels of competence as learners exit